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FINAL REPORT

REFORM OF THE LAWS DEALING WITH ADULT GUARDIANSHIP AND PERSONAL HEALTH CARE DECISIONS

Law Reform Commission of Nova Scotia
November 1995

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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., Co-President
Dawn Russell, Co-President
Ronald Culley, Q.C.
Theresa Forgeron
Jennifer Foster
Justice David MacAdam
Dale Sylliboy

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Law Reform Commission of Nova Scotia

TO: The Honourable J. William Gillis, Ph.D.
Minister of Justice

In accordance with section 12(3) of the *Law Reform Commission Act*, we are pleased to present the Commission's Final Report *Reform of the Laws Dealing With Adult Guardianship and Personal Health Care Decisions.*

Ronald Culley, Q.C., Commissioner

Theresa Forgeron, Commissioner

Jennifer Foster, Commissioner

William Charles, Q.C.
Co-President

David MacAdam, Commissioner

Dawn Russell
Co-President

Justice

Dale Sylliboy, Commissioner

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REFORM OF THE LAWS DEALING WITH ADULT GUARDIANSHIP AND PERSONAL HEALTH CARE DECISIONS

SUMMARY

In the summer of 1992 the Law Reform Commission began a project examining the law dealing with adult guardianship in Nova Scotia. The guardian of an adult is someone appointed by the court to make decisions for an adult when he or she, for a variety of reasons, is in need of assistance to make decisions about his or her personal or financial affairs.

The law in Nova Scotia dealing with the court appointment of adult guardians is contained in the *Incompetent Persons Act* and the *Inebriates Guardianship Act*. These laws, "inherited" from the laws of England, remain the same as when they were first adopted in the late 1700s. The Commission believes that these laws do not respond to current social needs and do not reflect current social values about the importance of personal autonomy. In particular, because orders under these *Acts* remove all decision-making power, they do not recognize that a person may need assistance with some decisions but not others.

Other important reasons for reform are that: these laws contain archaic and offensive language; they do not distinguish between guardianship of the person and guardianship of the estate; and, they do not contain a means of monitoring the extensive powers given to guardians.

This *Final Report* of the Law Reform Commission of Nova Scotia proposes a new law for Nova Scotia on adult guardianship called the *Adult Guardianship Act*.

During the consultation and research stages of the adult guardianship project it became apparent that advance health care directives, more commonly referred to as "living wills", could be a viable alternative to court imposed adult guardianship for personal and health care decision-making for some people. Advance health care directives allow individuals, while they are able, to exercise their autonomy in health care decisions in the event of incapacity. Currently, one form of advance health care directive is available in Nova Scotia in the *Medical Consent Act*. This *Act* allows a person to appoint another person to make decisions for them. Many people believe that other types of advance health care directives, such as those available in other provinces, should also be legal in Nova Scotia to better meet the needs of some people.

The Commission decided to proceed with research and consultation on advance health care directives as one alternative to guardianship in order to prepare a more comprehensive *Final Report* to the Government on adult guardianship. In November 1994 a *Discussion Paper*, *Living Wills in Nova Scotia* was published. In it the Commission recommended that both the proxy and the "living will" model be allowed. In addition, the Commission recommended that there be a list of people set out in the legislation to make decisions for a person who had

not taken advantage of these options when they were capable of doing so. The Commission recommended that the law have few formalities to make advance directives a practical and accessible option that fulfils the principles of autonomy and self-determination.

The draft *Acts* contained in this *Final Report* reflect the recommendations proposed by the Commission in its two *Discussion Papers*, *Adult Guardianship in Nova Scotia* and *Living Wills in Nova Scotia.* The recommendations were amended according to submissions received from government, individuals and groups with an interest in the topic, as well as a review of new legislation from other provinces.

Although both adult guardianship and advance health care directives involve decision-making by one person for another, there is an important difference. Adult guardianship involves depriving a person of his or her civil liberties and this means that reasonable safeguards are needed to protect them. Advance health care directives, on the other hand, involve an expression of autonomy and can be largely self-administered with minimal procedural safeguards. For this reason, and also for reasons of public ease of access, the Commission decided to prepare two separate draft *Acts*: the draft *Adult Guardianship Act* and the draft *Advance Health Care Directives Act*.

The Commission's recommendations on adult guardianship in this *Final Report* are that Nova Scotia's law dealing with the appointment of a guardian for adults should be based on the following principles:

* all adults have a right to autonomy and self-determination such that guardianship should be used only as a last resort;

* an adult who is the subject of a guardianship application should be presumed capable of making decisions until the contrary is clearly demonstrated;

* the assessment of the capacity of an adult should take into account the circumstances of the adult, the kinds of decisions the adult must make, the adult's way of communicating, and available support and resources;

* the court should not appoint a guardian unless alternatives, such as providing support and help, have been tried or carefully considered;

* a guardianship order should be the least restrictive one possible in the circumstances; and

* the wishes of the adult, particularly those expressed in an advance health care directive or an enduring power of attorney, should be taken into account by the court in considering an order of guardianship.

The law should provide for the separate appointment of a "guardian of the estate" and a "guardian of the person". Partial guardianship orders should be the usual practice rather than the exception and the court should indicate the extent and duration of the guardian's authority and the time when the order will be reviewed.

A proposed guardian should provide the court with a statement of intent as to how he or she will provide support and assistance to an adult in need of a guardian. The guardian should be screened for suitability, and there should be limits on what a personal guardian can consent to without the court's approval.

Currently there is no system in Nova Scotia to monitor the behaviour of estate and personal guardians. The Commission recommends that a new Office of the Public Guardian be established, which in combination with the Office of the Public Trustee, would screen applications for guardianship before they proceed to court, as well as monitor the decisions of guardians.

The law should provide for discharge of a guardian when: there is no longer a need; where the guardian is unable or unwilling to continue to act; or where the guardian has acted improperly or contrary to the guardianship order.

The majority of the Commission recommends adoption of the draft *Advance Health Care Directives Act*. There is a dissenting opinion by a Commissioner who is concerned that the availability of advance health care directives poses serious ethical and moral issues and may be open to abuse especially as health care resources are reduced. In the opinion of the dissenting Commissioner, this is particularly a problem where the line between actions which constitute assisted suicide or the premature termination of life support and situations where a person, while technically alive, will never regain consciousness or is terminally ill is not clear. If advance care directives are available they should only be in terminal cases with the maximum procedural protection to ensure the person's right to continue his or her life is respected.

The majority of the Commission recommends that the following principles apply to the law relating to advance health care directives:

The law in Nova Scotia should be reformed to permit a capable person who is 16 years of age or older to make a wider range of advance health care directives and the Government should adopt the draft *Advance Health Care Directive Act* to replace the *Medical Consent Act*.

Advance health care directives should be included in the law to allow a person to set out instructions or general principles about future health care decisions to be made on the maker's behalf as well as to allow a person to appoint a proxy to follow instructions and interpret the general principles concerning health care decisions set out in a directive or to make health care decisions on the maker's behalf.

An advance health care directive should be effective whenever a person is incapable of making health care decisions.

The law on advance health care directives should have few formal requirements to ensure that a person's wishes are respected and that the costs of making a directive are low.

The law should include a statutory list of health care proxies for those who have not made an advance health care directive but the maker of a health care directive should be able to specify who is not to act as his or her statutory proxy.

A person with capacity should be able to revoke an advance directive by making a later directive or a document setting out that the earlier directive is revoked or by destroying the directive or directing someone else to destroy it.

A person should be able to name any number of alternate proxies but joint proxies should not be allowed.

A capable person who has reached the age of 19 years should be presumed capable of acting as a proxy. A proxy should not be compelled to act and should be protected from liability if he or she acts in good faith according to the draft *Act*.

There should be a duty to follow instructions unless there are compelling reasons for not doing so and a proxy should have a duty to act according to what he or she knows of the maker's wishes or, if unknown, according to the maker's best interests. The proxy should not be allowed to delegate decision-making authority to another person.

There should be limits on what a proxy can consent to on behalf of the maker unless specifically authorized.

Health care providers should be protected from liability for complying with a directive or for not complying because they were unaware of its existence.

RÉFORME DU RÉGIME LÉGAL CONCERNANT LA CURATELLE AU MAJEUR ET LES MANDATS DE SOINS MÉDICAUX

SOMMAIRE[1]

Au cours de l'été 1992, la Commission de réforme du droit amorçait une étude relative au régime de protection légale des majeurs en Nouvelle-Écosse. Le(la) curateur(trice) au majeur est une personne nommée par le tribunal pour prendre des décisions au nom d'un majeur qui, pour diverses raisons, requiert de l'aide dans la prise de décisions concernant sa personne ou ses affaires financières.

La *Loi sur les personnes inaptes (Incompetent Persons Act)* et la *Loi sur la curatelle à la personne alcoolique (Inebriates Guardianship Act)*, régissent la nomination par le tribunal des curateurs(trices) au majeur en Nouvelle-Écosse. Ces lois, émanant de la tradition des lois d'Angleterre, n'ont pas été amendées depuis leur adoption au XVIII^{è} siècle. La Commission croit que ces lois ne répondent pas aux besoins sociaux actuels et ne reflètent pas les valeurs sociales actuelles relativement à l'autonomie des personnes. Par exemple, les ordonnances émises en vertu de ces lois retirent tout pouvoir décisionnel et ne reconnaissent pas qu'une personne puisse avoir besoin d'aide seulement dans la prise d'un certain type de décisions.

D'autres facteurs militent en faveur d'une réforme dans ce domaine: ces lois utilisent un langage archaïque et insultant, elles ne distinguent pas entre la curatelle à la personne et la curatelle aux biens et ne prévoient pas de mécanisme de contrôle des pouvoirs octroyés aux curateurs(trices).

Ce *Rapport final* de la Commission de réforme du droit de la Nouvelle-Écosse propose l'adoption d'une nouvelle loi en Nouvelle-Écosse relativement à la curatelle au majeur intitulée la *Loi sur la curatelle au majeur (Adult Guardianship Act)*.

Au cours des étapes de la recherche et de la consultation dans le cadre du projet sur la curatelle au majeur, les mandats de soins médicaux en prévision de l'inaptitude, communément appelés "testaments de vie" apparurent comme une alternative viable à la curatelle au majeur imposée par le tribunal en matière de décisions rattachées à la personne et aux soins de santé. Les mandats de soins médicaux en prévision de l'inaptitude permettent aux individus, alors qu'ils en ont la capacité, d'exercer leur droit à l'autonomie en matière de décisions médicales en cas d'inaptitude. Présentement, un tel mandat de soins médicaux en prévision de l'inaptitude existe en Nouvelle-Écosse dans la *Loi sur le consentement médical (Medical Consent Act)*. Cette loi permet à une personne de nommer une autre personne afin de prendre des décisions en son nom. Bon nombre de personnes sont d'avis que d'autres types de mandats de soins médicaux en prévision de l'inaptitude et

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

existant dans d'autres provinces, devraient aussi être valides en Nouvelle-Écosse afin de mieux répondre aux besoins de certaines personnes.

La Commission décida d'amorcer une étude et des consultations sur les mandats de soins médicaux en prévision de l'inaptitude comme alternative à la curatelle au majeur afin de préparer un *Rapport final* sur la curatelle au majeur plus complet pour le gouvernement. En novembre 1994, un *Document de réflexion sur les testaments de vie en Nouvelle-Écosse* fut publié, dans lequel, la Commission recommandait que les modèles du mandat de même que celui du "testament de vie" soient acceptés. En outre, la Commission recommandait que la législation comprenne une liste de personnes ayant le pouvoir de prendre des décisions pour la personne qui n'a pas opté pour ces modèles alors qu'elle était apte à le faire. La Commission recommandait que cette loi prévoit peu de formalités afin que les mandats de soins médicaux en prévision de l'inaptitude deviennent une option pratique et à la portée de tous, tout en respectant les principes d'autonomie et d'indépendance.

Les projets de loi inclus dans ce *Rapport final* reflètent les recommandations faites par la Commission dans ses *Documents de réflexion* sur la *Curatelle au majeur en Nouvelle-Écosse* et sur les *Testaments de vie en Nouvelle-Écosse*. Ces recommandations ont été amendées suivant les commentaires faits par le gouvernement, les personnes et groupes intéressés de même que suivant les nouvelles lois adoptées dans les autres provinces.

Quoique tant la curatelle au majeur que le mandat de soins médicaux en prévision de l'inaptitude impliquent la prise de décisions par une personne au nom d'une autre, une différence importante existe. La curatelle au majeur implique la perte de droits de la personne fondamentaux entraînant la nécessité d'avoir des garanties de protection raisonnables de ces droits. Le mandat de soins médicaux en prévision de l'inaptitude, quant à lui, démontre l'autonomie personnelle et peut être auto-géré avec des garanties minimales. Pour cette raison et aussi pour permettre un meilleur accès par le public, la Commission a décidé de rédiger deux projets de loi distincts: le projet de *Loi sur la curatelle au majeur* (*Adult Guardianship Act*) et le projet de *Loi sur les mandats de soins médicaux en prévision de l'inaptitude* (*Advance Health Care Directive Act*).

Les recommandations de la Commission sur la curatelle au majeur présentées dans ce *Rapport final* prônent les principes énumérés ci-dessous comme principes de base de la nouvelle législation sur la curatelle au majeur en Nouvelle-Écosse:

* tous les adultes jouissent du droit à l'autonomie et à l'indépendance de sorte que la curatelle ne devrait être utilisée qu'en dernier recours;

* l'adulte faisant l'objet d'une demande d'ouverture d'un régime de protection du majeur devrait être présumé capable de prendre des décisions à moins de preuve contraire claire;

* l'évaluation de la capacité d'un majeur devrait prendre en considération les circonstances associées à l'individu, les types de décisions devant être prises par le majeur, son aptitude à communiquer de même que le soutien et les ressources disponibles;

* le tribunal ne devrait nommer de curateur(trice) que si des alternatives telles l'apport d'aide et de soutien ont été tentées ou sérieusement prises en considération;

* une ordonnance de curatelle au majeur devrait brimer la liberté du majeur le moins possible dans les circonstances; et

* les désirs du majeur, particulièrement ceux exprimés dans un mandat de soins médicaux en prévision de l'inaptitude ou dans une procuration, devraient être pris en considération par le tribunal lors de l'émission d'une ordonnance de curatelle.

Le régime de protection devrait permettre la nomination d'un(e) curateur(trice) aux biens de même que d'un(e) curateur(trice) à la personne. La curatelle partielle devrait être ordonnée en règle générale plutôt qu'à titre d'exception. De plus, le tribunal devrait se prononcer sur la portée et la durée de l'autorité du(de la) curateur(trice) ainsi que déterminer la date à laquelle cette ordonnance devra être révisée.

La personne désirant être nommée curateur(trice) devrait avoir l'obligation de fournir au tribunal une déclaration de ses intentions quant à la façon dont elle entend aider et répondre aux besoins du majeur. Une évaluation du(de la) curateur(trice) devrait être faite afin de s'assurer que la personne nommée est la bonne personne pour remplir le mandat et des limites devraient être imposées quant aux décisions que le(la) curateur(trice) à la personne peut prendre sans l'autorisation du tribunal.

Présentement, il n'existe aucun système en Nouvelle-Écosse pour contrôler le comportement des curateurs(trices) aux biens et à la personne. La Commission recommande qu'un nouveau Bureau du curateur public (Office of the Public Guardian) soit crée pour filtrer, de concert avec le Bureau du fidéicommissaire public (Office of the Public Trustee), les demandes d'ouverture de régime de protection avant leur audition devant le tribunal, de même que pour contrôler les décisions des curateurs(trices).

La législation devrait prévoir la libération des curateurs(trices) dans les cas où leur intervention n'est plus nécessaire, lorsqu'ils(elles) sont incapables ou refusent d'agir ou lorsqu'ils(elles) ont agit de façon inconvenante ou contraire à l'ordonnance d'ouverture du régime de protection.

La majorité des Commissaires recommande l'adoption du projet de *Loi sur les mandats de soins médicaux en prévision de l'inaptitude* (*Advance Health Care Directive Act*). Un Commissaire a émis une dissidence à l'effet que le recours aux mandats de soins médicaux

en prévision de l'inaptitude soulève de sérieuses questions d'éthique et de morale et ouvre la voie aux abus, particulièrement à une époque où les ressources en matière de soins de santé périclitent. Ce Commissaire croit que le problème revêt un caractère plus aigu en raison du fait que les frontières entre un geste constituant une aide au suicide ou l'interruption prématurée de moyens artificiels maintenant une personne en vie, et la situation où une personne, artificiellement maintenue en vie, demeurera à l'état végétatif ou est en phase terminale, ne sont pas clairement établies. En cas de reconnaissance légale des mandats de soins médicaux en prévision de l'inaptitude, ces derniers ne devraient être acceptés qu'en cas de phase terminale et devraient être entourés de formalités de protection maximales afin de garantir que le droit à la vie d'une personne soit respecté.

La majorité des Commissaires recommande que la législation concernant les mandats de soins médicaux en prévision de l'inaptitude respecte les principes suivants:

> La législation en Nouvelle-Écosse devrait être amendée afin de permettre à une personne capable âgée de 16 ans ou plus, de donner un mandat de soins médicaux en prévision de l'inaptitude plus étendu. Le gouvernement devrait adopter le projet de *Loi sur les mandats de soins médicaux en prévision de l'inaptitude* (*Advance Health Care Directive Act*) afin de remplacer la *Loi sur le consentement médical* (*Medical Consent Act*).
>
> Les mandats de soins médicaux en prévision de l'inaptitude devraient être incorporés dans la législation afin de permettre à une personne de donner des instructions ou d'énoncer des principes généraux à suivre quant aux décisions relatives aux soins de santé qui devront être prises au nom du mandant et de nommer un mandataire qui devra suivre ces instructions, interpréter les principes généraux ou prendre des décisions relatives aux soins de santé au nom du mandant.
>
> Une décision relative aux soins de santé devrait toucher des questions de soins de santé et un mandat de soins médicaux en prévision de l'inaptitude devrait entrer en vigueur dès qu'une personne devient incapable de prendre des décisions relatives aux soins de santé.
>
> La législation concernant les mandats de soins médicaux en prévision de l'inaptitude devrait prévoir peu de formalités afin de garantir que les désirs d'une personne soient respectés et que les coûts afférents au recours à de tels mandats demeurent minimes.
>
> La législation devrait inclure une liste de personnes pouvant agir comme mandataire relativement aux décisions médicales dans le cas où un individu n'a pas fait de mandat de soins médicaux en prévision de l'inaptitude. Toutefois, la personne qui donne un tel mandat, devrait pouvoir spécifier les personnes à qui elle ne veut donner ce mandat.
>
> Toute personne possédant la capacité requise devrait avoir le droit de révoquer un mandat de soins médicaux en prévision de l'inaptitude qu'elle a donné en donnant de nouvelles instructions ou en rédigeant un document déclarant que le mandat antérieur

est révoqué ou alors, en détruisant le mandat antérieur directement ou avec l'aide de quelqu'un d'autre.

Une personne devrait avoir le droit de désigner un certain nombre de mandataires successifs, néanmoins, elle ne pourrait pas prévoir que des mandataires agiront conjointement.

Toute personne âgée d'au moins 19 ans et possédant la capacité requise devrait être présumée capable d'agir comme mandataire. Un mandataire ne devrait pas être forcé à agir et devrait être exonéré pour tout acte commis de bonne foi en vertu du projet de *Loi*.

L'obligation de respecter les instructions données devrait être imposée, à moins qu'il existe de sérieuses raisons pour agir autrement. Un mandataire devrait avoir l'obligation d'agir en fonction de sa connaissance des désirs du mandant ou, dans le cas où il ne connaît pas ces désirs, dans le meilleur intérêt du mandant. Le mandataire ne devrait pas avoir le droit de déléguer son pouvoir décisionnel à une autre personne.

Des limites devraient être posées quant au type de consentement pouvant être donné par le mandataire au nom du mandant en l'absence d'autorisation spécifique.

Les intervenants dans le secteur de la santé devraient être protégés dans les cas où ils ont respecté les instructions du mandant ou lorsqu'ils n'ont pas respecté ces instructions parce qu'ils ignoraient l'existence du mandat de soins médicaux en prévision de l'inaptitude.

Ta'n teli tetpaqatasikl teplutaqn' ujit
Adult Guardianship aqq tajikemkewel kisutaqn'

Nipkek 1992ek, Law Reform Kmisnaq wesku'tmi'tij teplutaqn ta'n teltek wjit Adult Guardianship ula Nopa Sko'sia. Ta'n teltek nike' nuji klo'teket telueket apoqnmuatl e'pilitl kisna ji'nml ta'n mu tepi nsɨtuoqnmlikul maliaptmuan wsulieweym kisna me' piluey koquey staqe ta'n tele'lij.

Wla teplutaqn Nopa Sko'siaewey ta'n ilumaji tanik weji mknasijik court-iktuk adult guardianaq, na etek Incompetent Persons Act-iktuk aqq Inebriates Guardianship Act-iktuk. Wla teplutaqnn, wejiaql Aklasiewe'l teplutaqnn, aqq nete' teltekl nkutey amskwes kisutasikek 1700's-ek. Kmisn na etlite'tk ula teplutaqnn mu majulkwatmitikw ta'n kiskuk mimajuaqnewey aqq mu wije'mukl ta'n teli te'tasik alsumsimk. Ketlsɨk msɨt ta'n teliwie'mumkl ewikasikl Actsiktuk kaqi apia'tawkuk wen ta'n teli alsumsij, eyk na mu wen nuta'q ta'n tijiw kisitasimk aqq eyk app na'tuen nuta'tɨsk.

App nikani ankite'taqn mimamuj kiwaskiwi'kmumkl staqa: teplutaqnn saqawe'l aqq eykl ajkinmuekl; mu piltui nenasinukl guardianship wjit mimajuinu aqq guardianship wjit ta'n koqewey alsutaqnn aqq mu eyknuk ta'n kisi tli jiko'tmumk mlkikno'ti kisi iknmuj ula guardianaq.

Ula kespetekewey Law Reform Kmisewey Report ujit Nopa Sko'sia kisitaq piley teplutaqn ujit Adult Guardianship aqq teluisik Adult Guardianship Act.

Kesk kekinuatatimkek aqq ilaptasikek ula adult guardianshipewey tla'taqn nemitasikɨp nikanutasikl ta'n telo'tasik wen teli tajike'k asite'lsuti'l, app tel nenasikl Adult Guardianship wjit mimajuinuey aqq tejike'mkewey telsutasikl wjit eyk wen. Nikanutasikl tajike'mkewe'l asite'lsutit'l asiste'lmaj mimajuinu'k, ke'sk tepaskmaj wen, kisi klusa'sit wen ta'n telkimut ta'n tijiw ejele'k nike', eyk newte'jk nikanutasik ta'n telo'tasik wen teli tajike'k Nopa Sko'sia etek Medical Consent Actiktuk. Ula Act asite'lmatl wenl mkenan pilue'l mimajuinu'l ilsutekewkn. Pikwelk wen ketlamsitasij eykl pilue'l nikanutasikl ta'n telo'tasik wen teli tajike'k, staqa nike' eykl pilue'l ktɨtkl Provinsl, tepias elt i'kn Nopa Sko'sia kulaman mej najiwli maliamaten eykik mimajuinu'k.

Komisn asite'tkɨp siawa'sin ilaqaptasikl aqq mawaknutmamkl wjit Adult Guardianship tla'taqnl wesku'tasik nikautasikl ta'n telo'tasik wen teli tajike'k newte'jkn piluey wjit guardianship kulaman kisi kiskaja'tuten me'j naji wulinsɨten Final Report wjit adult guardianship. Keptɨkeuikus 1994ek, Discussion Paper, Living Wills in Nova Scotia, tewiaqɨp komisn ulte'tkɨp komisn ulte'tkɨp kitk proxy aqq "living will" kisi ewe'wasin. Jel app. komisn ulte'tkɨp ten wisunl ta'n mimajuinu'k kismknujik legislationiktuk kulaman kisi ilsutekewatl wenl ta'n mna'q wesua'tulikl ula pilue'l etekl ta'n tijiw welasmutek. Komisn wlte'tk na teplutaqn mej mu tli espi'sn tla'taqn wjit nikanitasikl kulaman nsɨten aqq kisi wekasiten ta'n tijiw ketui apoqmaj wenl ke'sk kisi klusilij aqq ta'n wenl teli alsumsilij.

Komisn ta'n ulte'tkl wjit Adult Guardianship teekl ula Final Reportiktuk ketmoqjenk Nopa Sko'siaewey teplutaqnn ta'n asiste'kl wen nsutmasewulin tepias majulkwatmu ula etekl kisi wikasikl:

- msit mimajuinu'k wesko'tmitij kisi klua'sin wen aqq alsumsin mnknan kisi na moqo ta'n nestmawsewtl, aqq tepias nekmewel wstejk lian;

- mimajuinu ta'n kwilumaj nuji nestmawseljl tepias kjiu'ksin tepaskmat kisi tla'teku;

- ta'n tijiw wen iloqamuj tepias wiaqi to'amajaptasin msit koqoe'l, ta'n wen telsutekej, ta'n teli kinua'tekej aqq etuk eyk maliaptaqn aqq wen maliaptitew;

- court tepias mu mknan nuji anko'tekettl keskmnaq se'k lapteken, staqa maliaptaqn aqq apoqmasuti, kisi wjinu'katasik aqq menaqa kisi ankaptasik;

- nuji anko'tekewey ilsutaqn tepias mu tlte'tasin miamuj meki-toqomajo'teknuk, aqq;

- ta'n telipewatkl mimajuinu tepipuna'j, me app ta'nik wesku'tasikl, nikanutasikl tajike'mkewel asite'lsuti'l kisna siawwiak Power of Attorney, nutaql wiaqi wi'kasin anko'tasimkewey-kisutaqn-iktuk.

Ula ewsi-wikasik teplutaqn aqq etek Final Report-iktuk ulte'tmikewel kisitetkl Kmisn ula tapu'kl Discussion Paper-l, Adult guardianship in Nova Scotia aqq Living wills in Nova Scotia. Ula ultetmik-ewel kiwaskatasikipnu nkutey teli wi'kasikl tanl kisitetaqnn wejiakl kiplno'lewiktuk, newtejijik mimajwinu'k aqq tanik kesaptimitij ula wesku'tasik, aqq nkutey lpa ta'n ilaptasikel teplutaqnn tle'l ktikl province-l.

Tlia lpa kitk adult guardianship aqq nikanutasikl tajike'mkewel asite'lsuti'l wiaqiak newtejit wen ilsuteken wjit pilue'l wenl, espe'k na ta'n teli pilu'tekl. Adult guardianship na ejikla'toql eikl alsumsimkewel klaman jel tlia maqitewel klo'taqn nuta'kl ta'n anko'tal. Tajike'mkewl asite'lsuti'l, awanaqa, wesku'tmitij kisutaqn wjit kelusa'simk aqq kisi maliamsitew wen kesk mu piquelk ankotaqn nuta'nuk. Na wjit ula, aqq wjit ta'n mimajwinu'k tli nqamasi ktimo'taq, kmisn kisitetk lukwatnn tapu'kl tepkise'kel ewsiwi'kasikel teplutaqnn: ta'm ewsiwi'kasik Adult guardianship Act aqq ta'n ewsiwi'kasik Advance Health care Directives Act.

Tepias na teplutaqn ajela'tun ta'n tli tepkisi mknut ta'n "nuji anko'tk utmo'taqn" aqq maw "nuji ankweywatl mimajwinu'l." Pukwe'l anko'tekemkewel kisutaqn nuta'ql ewe'wasin aqq katu moqwe' aqq kort nuta'q kinua'tiken ta'n tuju aqq telipije'k ta'n nuji anko'teeket eli alsusit aqq ta'n tuju tele'k kisutaqn ilaptasitew.

Ta'n wen nuji anko'teket nutak kortal kinuwa'twan ta'n ketui tlatikej wjit ta'n nekem tli apoqnamwatal mimajwinu'l ta'n nutaj anko'tasin, nuji anko'teket nuaq teto'qi ankamuksin wjit ta'n tetujaskmat, aqq nutaq klo'tasin ta'n nuji anka'teket tesek kisutk keskmnaq kort asite'taqnm nutanuk.

Suel msit komisnaq ulte'tmi'tij wsua'tunew ta'n maqitweikasikl Advance Health Care Directives Act. Pasik na mu kaqi wlte'tekek Commissioner, telte'tk nekm ta'n koqoe'l etekl nikani wikasikl wjit ta'n wen teli tajike'k tla'taqn eyk to'q ta'n mu tutanl newte telita'sultik nukl aqq mu newte teli klamsitmi'tikl commissione'l toqo jiptuk emeko'taqn i'kitew elmi'knik aqq wen ta'n nekm commission mu welte'tmuk, ula lukwaqna'lwek jiptuk kasi wi'katew ta'n tetpisa'toq wen apoqnmuj nepa'sij, kisna mentaqoluj wen tlia' mej pemawsij, ma app tukiek, kisna kesi ksnukwat, ma wtawsik, na nekmewe'l mu paqi nenmitl. Tek nikani wikasikl wjit ta'nik ma wjawsulti'k toqo toqomajo'tasin ta'n ewekasimk kulaman ma wen mimajuinu wnpuaqnm wjianuk.

Nike' na, mu eiktnuk ewekasik ula Nopa Sko'sia wjit teli jikeyuj telataqiti'tij tanik nuji anko'tmitij utmo'taqn aqq mimajwinuk. Kmisn ulte'tk piley Office of the Public Guardian qama'tasin, ta'n maw wiaqatasik Office of Public Trustee' iloqaptital etawatmamkewel wjit nuji anko'teket keskmnaq elta'nuk kortiktuk, aqq maq ta'n iloqaptital nuji ankotataqitijik kisutaqnmwal.

Nutaq teplutaqn a'jela'tun wjit ta'n tli mina'laten nuji anko'teket elmiaq mu nuta'q kisna ta'n tuju nuji anko'teket mu kisi tla'tikek kisna mu ketui siaw tla'tikek, kisna kisi o'pla'tiket kisna kisi psipka'tok anko'tekemkewey kisutaqn.

Suel msit kmisn-ak ulte'tmitij ula nike' pemwikasikl nasa'tasin teplutaqn-iktuk ta'n wesku'tmitijl nikanutasikl tajike'mkewel asite'lsuti'l:

- Nopa Sko'sia-ewey teplutaqn nutaq ila'tasin klaman asite'tew ujit ta'n wen newtiska'q-jel-asukuom tepi puna't kisna aji kisikuit ltun mej naji milamu'kl nikanutosikl tajike'mkewel asite'lsuti'l aqq kipno'l tepias usua'toq na ewsiwikasik Advance Health Care Directives Act klaman mnteskitew Medical Consent Act.

- Nikanutasikl tajike'mkewel asite'lsuti'l nuta'q wiaq wi'kasin teplutaqn-iktuk ujit asite'lman mimajwinul msaqn wi'kmn keknukwaqn kisna ta'n pasik kisutaqnn wjit elmi'knik-ewel tajike'mkewel kisutaqn kisitasin ujit nekm aqq maw ilpukwa'luksin nujsutekewtl majulkwatmlin telutaqn aqq elsutmn ta'n pasik kisutaqnn ujit tajike'mkewel kistaqnn ta'n ewikasikl asite'lsutiktuk kisna ltun tajike'mkewel ilsutaqnn ujit ta'n wen kisutkl.

- Tajike'mkewey kisutaqn nuta'q ilutasin klaman wiaqiatel tajike'mkewel koquel aqq tajike'kewey ilutaqn kisa'tiketew ta'n tuju wen mu kisutmuk tajike'mkewey.

- Wla teplutaqn ujit nikanutaqn tajike'mkewey nutaq wiaqian kwilulasikl klaman wen ta'n tel menwekej ketlamite'tasitew aqq ma tli mkotinuk ta'n telitemk kisutaqn.

- Teplutaqniktuk na nutaq wiaqi wikasin utuisunmwal tajike'mkewek proxy-aq wjit ta'n wenik mu kisitutikl nikanutasikl tajike'mkewel kisutaqn katu ta'wen kisitoq tajike'mkewey tepias kisumaj ta'n wenl mu menwekekl wjit u-proxy-ml.

- Mu nutan'nuk telite'taqn ujiasin elmiaq wen mu kisituk nikanutasik tajike'mkewey kisutaqn kisna ta'n tuju kiwaskutk.

- Mimajwinu ta'n tepaskemat tepias kisi kiwaskutmn nikanutasik kisutaqn elmiaq ta'n tuju ktek ltoq kisna wi'katikn telwek nikanitasikɨp na kiwaskutasik kisna twiskintoq na kisutaqn kisna lulaj natwenl twiskinotun.

- Tepias wen kisi wi'tan ta'n pasɨk te'siliji proxy-aq katu toqi proxy-aq nutaq mu asitetasinew.

- Ta'n wen tepaskmat aqq newtiskaq jel wkmujin te'sipuna't tepias tlitetasin tepaskman proxy-ewin. Proxy na tepias mu ktmoqjaluksin lukwen aqq tepias ikaluj wejatikemk elsu'tmaqn elmiaq nekm tetpaqatikej aqq majulkwatk ewsiwi'kasik Act.

- Nu'ta'q na mlki anko'tasin aqq majulkuasin ilutasikl misoqo i'k natukowey ta'n telwek mu nuta'nuk aqq proxy nutaq kwilumuksin tla'tiken ta'n teli nsɨtwaj ta'n wenl ilsutekeli'jl, kisna mu kjiji'aq telapukwelij mlki klotmwan wlliaqm. Nutaq proxy mu asite'tasin wenl lulan anko'tmlin kisutaqn.

- Nuta'q ika'tasin keknue'kl ta'n koque'l ta'n proxy kisi asitetkl ujit kisutekelitl misoqo katu keknui luluj.

- Weqaiw proxy kisitoq tajike'mkewel kisutaqn nutaq usko'tmn tajike'mkewey kinua'taqn ta'n asite'lmut we'wmn ujit teli ilutekej.

- Nuta'q teplutaqniktuk ten keknuekewel ta'n asitelmatl kisutekelitl matnamu elmiaq tlsumuj mu kisaiasin aqq asitetasin wen piluey ta'n sespete'tk kwilutmu iloqaptasin tlitelmaj proxy-al kaqɨsmilatekelim.

- Nuta'q ikaluksinew tanik tajike'mkewey maliaptimtij aqq mu lsu'tmuksinew koquey ujit teli ktlamsitk kisutaqn kisna ujit mu ketlamsitmuk mɨta ma kejitukɨp i'kten.

- Nut'aq teplutaqn ketlamitetɨmn ikanutasikl tajike'mkewel kisutasikl ta'n wejita'ql ktekl province-l.

I INTRODUCTION

A. The Adult Guardianship and "Living Wills" projects

In the summer of 1992 the Law Reform Commission began a project to examine the law dealing with adult guardianship in Nova Scotia. The guardian of an adult is someone appointed by the court to make decisions for an adult when he or she, for a variety of reasons, is in need of assistance to make decisions about his or her personal or financial affairs. There are a number of situations in which a person might need assistance in making decisions. Some of the most common involve head injury, mental illness or disability, stroke, a degenerative brain disease such as Alzheimer's, or being elderly and otherwise having diminished capacity to make or communicate decisions.

The law in Nova Scotia dealing with the court appointment of someone to make another person's decisions is contained in the *Incompetent Persons Act*[2] and the *Inebriates Guardianship Act*[3]. These laws, "inherited" from the laws of England, remain the same as when they were first adopted in the late 1700s.

The Commission believes that these laws do not respond to current social needs and do not reflect current social values about the importance of respecting personal liberty and autonomy. In particular, they do not recognize that a person may need assistance with some decisions but not others. The existing law removes all decision-making power from a person when the court appoints a guardian for him or her and this is often unnecessary.

Adults who need assistance in decision-making usually receive it from family or friends without involving the law at all. However, in some cases an informal relationship may not be sufficient. This is the case for legal transactions such as signing leases and contracts or other banking documents. In these situations, it is necessary to have a legal arrangement for another person to make the decisions on behalf of the person in need of assistance.

Other important reasons for reform are that the existing laws contain archaic and offensive language, do not distinguish between guardianship of the person and the estate, do not adequately deal with personal guardianship, do not provide for partial guardianship orders, and do not contain a means of monitoring the extensive powers given to guardians.

To assist it in its research the Commission formed an advisory group, listed in Appendix A, comprised of individuals drawn from various sectors of the community. Their time and contribution to this project was greatly appreciated.

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[2] R.S.N.S. 1989, c.218.

[3] R.S.N.S. 1989, c.227.

The Commission published its preliminary suggestions for reform in September 1993 in a *Discussion Paper, Adult Guardianship in Nova Scotia: Suggestions for Reform of the Incompetent Persons Act* and invited public comment and responses. A list of people and agencies who responded to the *Discussion Paper* is found in Appendix B.

During the consultation and research stages of the project it became apparent that advance health care directives, more commonly referred to as "living wills", could be a viable alternative to court imposed adult guardianship for personal and health care decision-making for some people. Advance health care directives allow individuals, while they are able, to express their personal autonomy in decisions that will affect them in the event of their incapacity. Currently, one type of advance health care directive is available in Nova Scotia in the *Medical Consent Act*[4]. This allows one person to appoint another person to make decisions for them. Many people believe that other forms of advance health care directives should also be legal in Nova Scotia to better meet the needs of some people.[5] Advance health care directives in a variety of forms are available under laws in other provinces. It has been suggested by the *Report of the Senate Committee on Euthanasia and Assisted Suicide*[6] that reform is necessary to ensure consistency between Canadian provinces.

The Commission decided to proceed with research and consultation on advance health care directives as one alternative to guardianship in order to prepare a more comprehensive *Final Report* on adult guardianship. An advisory group comprised of individuals in the community and agencies interested in this issue assisted the Commission in its work on this topic. The names of the advisory group members are found in Appendix A. Their contribution to this project and the Commission's work is gratefully acknowledged.

In November 1994, a *Discussion Paper, Living Wills in Nova Scotia,* was published and the Commission invited public comment. A list of people and agencies who responded in writing or orally to the Commission's *Discussion Paper* is found in Appendix B.

The recommendations and the two draft *Acts* contained in this *Final Report* reflect some of the suggestions proposed by the Commission in the two *Discussion Papers*, amended in

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[4] R.S.N.S. 1989, c.279.

[5] The type of directive available under the *Medical Consent Act* is not widely known in either the medical or legal community: R.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). The study showed that only one-third of physicians and two-thirds of lawyers who responded to a mailed questionnaire were aware of the *Medical Consent Act*.

[6] *Of Life and Death* (Ottawa: Ministry of Supply and Services, 1995). People are often confused about the relationship between assisted suicide and advance health care directives. A person can only direct a decision in an advance health care directive that is lawful. For example, a person may refuse medical treatment even though the refusal may or will result in death. However, assisted suicide is not lawful in Canada. This means that a clause directing such an *Act* in an advance health care directive would have no force of law.

response to suggestions received by the Commission as well as additional research and examination of laws recently enacted in other provinces.

Although both adult guardianship and advance health care directives involve decision-making by one person for another who cannot legally make decisions, there is an important difference. Guardianship involves an application for a court order by one person concerning another. The court order, in effect, removes or limits the individual's autonomy and civil liberties. Because of this infringement, it is important to ensure that there are safeguards to protect individuals from abusive situations or from any greater loss of liberty than that necessary to assist them. At the same time, it must be understood that the majority of guardianship applications involve someone seeking to assist another person, often a family member, to make legal decisions. To encourage people to help in this way, the process must not be too expensive or difficult or people will not agree to take on the responsibility of guardianship. Health care directives, on the other hand, involve an expression of personal autonomy and can be created with little or no legal involvement. Fewer safeguards are needed since the person involved has had the opportunity to exercise his or her autonomy in making the directive. For this reason, and also for reasons of public ease of access, the two subjects are dealt with in separate draft *Acts*, rather than in one. The two draft *Acts* with commentary explaining some of the provisions are found in Parts V and VI of this Report.

The rest of this Report will outline the current law in Nova Scotia, reforms that have been made elsewhere and the values that the Commission feels should be reflected in the law. It will suggest how those values might be implemented into the new laws. The main recommendation of the majority of the Commission is that the draft *Acts* to reform the law on adult guardianship and to allow a broader range of advance health care directives be adopted by the Government of Nova Scotia.

B. Language

The Commission attempts in its *Discussion Papers* and *Final Reports* to write about law and the subject of its Reports in such a way that those without legal training can understand and comment on the Commission's recommendations. In each project there are words used which, because they are special medical or legal terms, may not be familiar to all readers.

In this Report:

adult guardianship refers to the law relating to the way a person is appointed to make another person's decisions;

advance health care directive is a legal document which either appoints someone to make health care decisions for the maker in the event of incapacity or that sets out specific instructions or general principles about health care matters, or both;

artificial hydration & nutrition	is a medical procedure used when a person is no longer able to drink or eat and normally involves feeding through a tube into the stomach or through the injection of fluid into a vein;
guardian of the estate	is a person who is a legal substitute decision-maker concerning another person's financial matters;
guardian of the person	is a person appointed as legal substitute decision-maker concerning another person's personal matters (often health-related);
life support	are machines used to keep a person alive by maintaining circulation and breathing (ventilation);
persistent vegetative state	is a coma which results from the loss of brain functions relating to consciousness and feelings although the body may continue to function;
proxy	is a person appointed in an advance health care directive to make health care decisions for someone else or to carry out the person's instructions or interpret general principles set out in the directive;
statutory proxy	is a person appointed from a list of persons set out in legislation (a statute) to make health care decisions for someone; and
terminally ill	is an irreversible condition that cannot be cured and that will eventually result in death.

II THE LAW IN NOVA SCOTIA AND ELSEWHERE

It was pointed out in the Introduction that this Report deals with two forms of decision-making for people who are in need of assistance to make legally binding decisions. These two forms of decision-making are: court ordered guardianship of the estate and the person, and advance health care directives. In order to keep the differences between the two clear, they will be discussed separately in this Part and Part III which deals with specific recommendations for reform.

Section A below sets out the current law on adult guardianship in Nova Scotia and elsewhere. Section B sets out the current law on advance health care directives in Nova Scotia and elsewhere. While the laws enacted in other provinces are not necessarily appropriate for Nova Scotia, movement of people between provinces means that the laws across Canada should be similar. Uniformity of law also has some practical implications in the enforcement of court orders in one province that were granted in another province.

A. Adult Guardianship

1. The law in Nova Scotia

It was noted in Part I that the *Incompetent Persons Act* deals with the situation where a person needs to have legally binding decisions made for him or her by another person. However, court ordered guardianship is only one way in which a person can obtain assistance. In fact, it is often the last resort where a person has not made any other arrangements ahead of time. For example, many people who anticipate the fact they may be in need of assistance to make some financial decisions, will draw up a document called an enduring power of attorney which legally appoints another person to make these decisions for them.[7] This Report does not specifically deal with the appointment of a power of attorney.[8]

Under the *Incompetent Persons Act*, a relative or friend of an adult may bring an application to court to have a guardian appointed for the adult. A committee of the social services district where the person lives may also start the process. Often, the municipal unit which houses an elderly person will ask the Public Trustee to bring an application under the *Act* to allow the municipality to make financial arrangements for the adult's housing and personal needs.

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[7] *Powers of Attorney Act*, R.S.N.S. 1989, c.352 .

[8] There has been some concern about the lack of monitoring and protection offered to people who have granted a power of attorney because this document can give extensive control over another person's finances and may be open to abuse.

The *Incompetent Persons Act* still uses offensive language such as "insane person" and "lunatic" which it defines as "a person, not an infant, who is incapable from infirmity of the mind of managing his own affairs". This language itself can cause distress for many people in that it applies an incorrect label or creates a stigma for the person who is in need of assistance.

The *Incompetent Persons Act* requires proof of two things to have a guardian appointed:

- that the adult has a mental "infirmity"; and
- that as a result of the "infirmity" the adult is "incapable" of managing his or her affairs.

Because of this dual requirement, people will not be found by the court to be "incompetent" simply because they are "incapable of managing their affairs". There must also be evidence of a mental "infirmity".

The procedure for the appointment of a guardian involves two steps. The first involves an application to the court seeking the appointment of a guardian. The law does not require notice to the adult who is thought to be in need of a guardian. The application is supported by sworn or affirmed statements (called "affidavits") of two medical practitioners. These affidavits, together with other documents, are sent to the Supreme Court with a request for a hearing.

The second step involves service of the notice of the date of the court hearing as well as the affidavits upon the adult who is the subject of the application and upon any person who may have the adult in his or her charge. At the court hearing, if no one opposes the application, and if the documents are in order, the judge will sign the order. In practice, applications are rarely opposed and when questions arise they usually relate to who should be appointed guardian and not to whether or not a guardian should be appointed. Guardians are often appointed by the court on the basis of the medical affidavits without oral evidence from either medical practitioners or from the adult thought to be in need of a guardian.

If a person is found to be "incapable of taking care of himself", the *Incompetent Persons Act* provides that the court will appoint a guardian and that person is the guardian of the person and of the estate since the *Act* does not allow a separate appointment for the estate and the person. In practice, judges will appoint a separate estate and personal guardian although in many cases, the same person is appointed to be both estate and personal guardian for the adult.

A person who is appointed guardian under section 3 of the *Act* has the "care and custody of the insane person and the management of the insane person's estate until legally discharged". In order to provide some means of assuring accountability for financial resources, the guardian is obliged to give a bond on conditions set out by the court. Private trust companies and the Public Trustee, however, are not required to give bonds. There are no other

enforcement or monitoring mechanisms to ensure that a guardian is complying with an order or to determine whether the person is still in need of a guardian. The standard of care for the guardian of the estate set out in section 11 of the *Incompetent Persons Act* is to "manage the estate frugally and without waste".

An order made under the *Incompetent Persons Act* effectively removes the rights of the person who is the subject of the order to deal with her or his property, to consent to or to refuse medical treatment and to carry out civil rights such as voting, marrying or divorcing, making a will, defending oneself in court, and so on.

There are also several other *Acts* in Nova Scotia dealing with people in need of guardianship or adult protection. The *Inebriates Guardianship Act* allows for a legal declaration that a person is incapable of managing his or her own business affairs because of "habitual drunkenness". The means of assessing this situation are not set out in the *Act* but the consequences of finding it are equivalent to the appointment of a guardian under the *Incompetent Persons Act.*

There are also provisions under the *Adult Protection Act*[9] which deal with intervention where an adult is the subject of abuse or neglect. This is an important area of law and social concern which is being examined by the Health Law Institute of Dalhousie University.[10] However, the focus of this Report is adult guardianship and advance health care directives and the Commission felt that adult protection was a topic that should be dealt with separately.

There is also an administrative system in the government which responds to several situations where a guardian is needed. These are the laws and administrative system of the Public Trustee. The Public Trustee is a government office which was established in Nova Scotia in 1973 under the *Public Trustee Act.*[11] The Public Trustee has many roles, one of which relates to adult guardianship. The Public Trustee becomes involved with adult guardianship in the following ways:

(i) as court-appointed guardian of the estate under the Incompetent Persons Act

When no one else is available or willing to become the guardian of an estate, the Public Trustee may apply to be appointed. In many instances, this type of guardianship service is requested by a municipality seeking help in collecting expenses for an elderly person in a

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[9] R.S.N.S. 1989, c.2.

[10] Elder Abuse Legislation Research Project, Dalhousie Law School, Dalhousie University, Halifax. This research suggests that adult protection measures are often used for instances where it would be more appropriate to use adult guardianship. For articles in the public press on elder abuse, see *e.g.,* S. Stanley, "Financial Abuse of the Elderly" and "The Invisible Victims" (1995) 15(4) *Maturity,* 25 and 26 respectively.

[11] R.S.N.S. 1989, c.379.

home for special care. The Public Trustee's Office is not, however, designed to provide personal guardianship services and the Public Trustee will not act as guardian of the person.

One of the difficulties which arises as a result of this lack of personal guardianship services from the Public Trustee's Office is that frequently there is no one appointed as the guardian of the person, even when the Public Trustee is appointed as guardian of the estate.

(ii) as guardian under the Hospitals Act[12] and the Adult Protection Act[13]

Under the *Hospitals Act*, a hospital may notify the Public Trustee to assume management of the estate of a patient who has no guardian and is "incapable" of administering his or her own estate. Similarly, the *Adult Protection Act* authorizes the Public Trustee to assume immediate management of the estate of an adult "in need of protection". Many of the cases which are referred to the Public Trustee under these laws eventually require the services of a full-time guardian and the Public Trustee may apply to be appointed guardian of the estate under the *Incompetent Persons Act*.

(iii) medical consent to treatment under the Hospitals Act

The Public Trustee may also be called upon to consent to treatment of a mentally "incapacitated" hospital patient. Under the *Hospitals Act*, if the hospital is unable to get consent from a patient and if the patient's spouse or next of kin is not available or consent is unable to be obtained, the Public Trustee may consent to the treatment.

2. The law elsewhere in Canada

A number of provinces and territories in Canada have recently reformed their adult guardianship legislation. Alberta, British Columbia, Manitoba, the Northwest Territories, Ontario, Quebec, and Saskatchewan all have some form of new legislation,[14] although the laws in British Columbia, Manitoba and the Northwest Territories are not yet in force. The British Columbia and Ontario *Acts* are part of comprehensive packages of legislation. Manitoba's legislation, *The Vulnerable Persons Living with a Mental Disability Act* deals only with some individuals in need of a guardian. The remaining provinces and territory including Nova Scotia, are without modern legislation on adult guardianship. Although

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[12] R.S.N.S. 1989, c.208.

[13] R.S.N.S. 1989, c.2.

[14] *Public Trustee Act*, R.S.A. 1980, c.P-36; Bill 49, *Adult Guardianship Act*, 2d Sess., 35 Leg., British Columbia, 1993; Bill 30, *The Vulnerable Persons Living with a Mental Disability and Consequential Amendments Act*, 4th Sess., 35 Leg., Manitoba, 1993; Bill 3, *Guardianship and Trusteeship Act*, 6th Sess., 12 Leg., Northwest Territories, 1994; *Advocacy Act, 1992*, S.O. 1992, c.26, *Consent to Treatment Act, 1992*, S.O. 1992, c.31, *Substitute Decisions Act, 1992*, S.O. 1992, c.30; *Public Curator Act*, S.Q. 1989, c.54, *Quebec Civil Code*, S.Q. 1991, c.64; *The Dependent Adults Act*, S.S. 1989-90, c.D-25.1.

Prince Edward Island has draft legislation under review,[15] it was introduced in 1995 but did not get beyond first reading in that session of the Legislature.

The Alberta *Act* proclaimed in 1978 was the first reformed legislation. It reflects the evolving interest in autonomy and the values later reflected in the *Canadian Charter of Rights and Freedoms*.[16]

> The *Act* is based on the philosophy that an individual should be allowed to retain as much authority as possible to make daily living decisions and that the state should interfere in the least restrictive way to assist the individual and only when it is absolutely necessary to do so.[17]

The Saskatchewan legislation is similar in form and content to the Alberta legislation as is the Bill not yet proclaimed from the Northwest Territories.[18] However, the Northwest Territories Bill also provides for the appointment of a Public Guardian who may act as guardian of the person where no suitable person is willing or able to do so.

The principles of reform, some of which have been achieved in modern adult guardianship legislation are:

> The legal and social relationship known as guardianship is an extreme form of interference in the life of an adult and should be used only as a last resort. It should involve the least restrictive, intrusive, stigmatizing and depowering mode of intervention necessary to meet an adult's needs, which reflects an adult's wishes to the maximum possible degree. The need for intervention, the level and form of intervention, and an adult's wishes should be ascertained through a multi-disciplinary capacity and needs assessment. If the need exists, the adult should be assisted by a competent and caring individual or agency, under a clear duty to follow a prescribed philosophy and fulfil prescribed tasks, appointed following a procedure consistent with the *Charter of Rights and Freedoms* in an accessible, helpful, friendly, but rigorous forum.[19]

B. Advance Health Care Directives

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[15] Bill 45, *Adult Guardianship and Supported Decision Making Act*. 3rd Sess., 59th leg., P.E.I., 1995.

[16] Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11 (hereinafter the *Charter*).

[17] M.E. Hughes, "Personal Guardianship and the Elderly in the Canadian Common Law Provinces: An Overview of the Law and Charter Implications" in M.E. Hughes & E.D. Pask, eds., *National Themes in Family Law* (Toronto: Carswell, 1988) at 138.

[18] *The Dependent Adults Act*, S.S. 1989-90, c.D-25.1; Bill 3, *Guardianship and Trusteeship Act*, 6th Sess., 12 Leg., Northwest Territories, 1994.

[19] R.M. Gordon & S.N. Verdun-Jones, *Adult Guardianship Law in Canada* (Toronto: Carswell, 1992) at 6-38.

1. 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* which was passed in 1988.[20] It allows a capable adult to appoint another person to give consent to treatment on the adult's behalf should the adult be unable to do so. This form of advance health care directive is sometimes called the "proxy" model in that it involves one person making the decisions for another. If a person does not appoint another person to make their decisions for them, then under Nova Scotia's *Hospitals Act* the next-of-kin gives consent to treatment.[21] This authority is limited to patients admitted to hospital and the scope and authority is limited to consent to treatment.

The *Medical Consent Act* requires that the appointment of a proxy be in writing, be signed by the maker and be independently witnessed by two people. There is no specific form required in the *Act*. The appointment of the proxy is cancelled either when the person making it revokes it, when a judge revokes it, or when a court appoints a guardian. The court also has the ability to revoke the authority of a proxy who is deemed "incapable", and to substitute another person.

While this form of advance health care directive is helpful to some people, it requires that the adult have a person who they can appoint. In addition, it can place a great deal of responsibility on the decision-maker, particularly if his or her decision is one with which other members of a family or the physician disagree. The person making the appointment may tell the person what their wishes are but, under the current law, there is no provision allowing a person to give directions which are binding. For this reason, many groups in Nova Scotia and elsewhere have advocated for a system which allows for other forms of advance health care directives such as "the instruction directive", more commonly known as the "living will". In their view, these options better provide for personal control over decision-making about health care.[22]

2. The law elsewhere in Canada

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[20] R.S.N.S. 1989, c.279.

[21] R.S.N.S. 1989, c.208, s.54(2). The next of kin in the *Act* is the person shown as such on the records of the hospital.

[22] *E.g.,* Canadian Pensioners Concerned, *Resource Package on Living Wills*, 1995. See also W. Molloy & V. Mepham, *Let Me Decide* (Toronto: Penguin, 1992).

Four provinces (Manitoba, Newfoundland, Ontario, and Quebec) have reformed their law to allow other forms of advance health care directives.[23] British Columbia enacted legislation a couple of years ago which is not yet in force.[24] Several provinces and one territory (Alberta, New Brunswick and the Northwest Territories) are also considering reform.[25] In addition, the Uniform Law Conference of Canada recommended that provinces pass a law recognizing advance health care directives made in other provinces which would be in keeping with the freedom of movement between provinces.[26]

The language used in each province varies somewhat as does the particular mix of types of advance health care directives and the administrative systems created to deal with them. In general, however, the purpose of the laws is similar in that they are intended to provide an opportunity for adults to give legally binding direction as to their health care in the event that they cannot consent to treatment in the future. The main differences arise in connection with the range of advance health care directives available and the systems created to administer them.

(a) Manitoba

Manitoba was the first province to pass advance health care directive legislation which includes both the proxy and the instruction or "living will" model. In July 1993, the *Health Care Directives Act* came into force.[27] The *Act* provides a mechanism to give legally binding effect to a person's wishes, expressed while capable, when the person does not have decision-making capacity. The *Act* allows this to be achieved in a document called a health care directive in which the person can either give or refuse consent to future medical treatment, can appoint one or more proxies (including joint proxies) to make health care decisions in the event of incapacity, or both. This *Act* defines a health care decision as "consent, refusal to consent or withdrawal of consent to treatment." The directive is effective when the maker ceases to have capacity concerning a proposed treatment or is unable to communicate his or her wishes about the treatment. Any person over the age of 16 years may make a directive if it is witnessed. There is no particular form required and the directive need not be registered. The *Act* provides for revocation of the directive by a later directive or

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[23] *Health Care Directives Act*, S.M. 1992, c.33; *Advance Health Care Directives Act*, S.N., 1995; *Advocacy Act, 1992*, S.O. 1992, c.26, *Consent to Treatment Act, 1992*, S.O. 1992, c.31, and *Substitute Decisions Act, 1992*, S.O. 1992, c.30; *Civil Code of Quebec*, S.Q. 1991, c.64 and *Public Curator Act*, S.Q. 1989, c.54.

[24] Bill 48, *Representation Agreement Act*, 2d Sess., 35 Leg., British Columbia, 1993.

[25] *Report of the Special Senate Committee on Euthanasia and Assisted Suicide: Of Life and Death* (Ottawa: Ministry of Supply & Services, 1995) Appendix J.

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

[27] S.M. 1992, c.33.

a writing indicating an intention to revoke it, or by destruction with the intention of revoking it. In addition, a directive is automatically revoked on divorce where the maker's spouse is appointed as proxy. The *Act* deals with potential conflict with the *Mental Health Act*[28] committal procedures by giving precedence to the *Mental Health Act*. It provides for protection for the person making the directive who does not agree that they are not capable, by providing that the maker is deemed capable of instructing counsel in any proceeding in which the maker's capacity to make health care decisions is at issue. The *Act* also provides for court review of misconduct by a proxy. Health care providers who act contrary to the wishes expressed in the directive are protected where they did not know of its existence or contents. Health care providers are further protected by not having a duty to inquire as to the existence or the revocation of a directive. The Manitoba *Act* provides a useful working model and a number of its provisions have been adopted in part or in whole in the draft *Act* at the end of this Report.

(b) Newfoundland

The most recent legislation dealing with advance health directives was passed in Newfoundland in 1995 as the *Advance Health Care Directives Act*[29] and came into force in July 1995. It is somewhat different in its structure from the Manitoba legislation but provides for much the same range of options. For example, like the Manitoba legislation, it allows for the proxy and the living will model or both. However, it also allows the maker to set out general principles as well as specific instructions. It also allows joint proxies. The Newfoundland *Act*, unlike the Manitoba *Act*, provides a statutory list of those who are to give consent when the person has not appointed a substitute decision-maker and the person does not have a guardian. The procedural safeguards in the *Act* are: informing the maker of the finding of incapacity and the fact that it can be contested if a second opinion confirms the incapacity; having an assumption of capacity to inform counsel; and allowing review of misconduct by any interested person. Advance health care directives are available for all health care decisions which are broadly defined as:

> ".... consent, refusal to consent, or withdrawal of consent of any care, treatment, service, medication, or procedure to maintain, diagnose, treat, or provide for an individual's physical or mental health or personal care and includes life-prolonging treatment, psychiatric treatment for a person who has not been admitted under...the *Mental Health Act* to a treatment facility,
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> the administration of nutrition and hydration and admissions, other than under...the *Mental Health Act*, to treatment facilities and removal from those institutions."[30]

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[28] R.S.M. 1987, c.M110.

[29] S.N., 1995.

[30] *Ibid*. s.2(b).

The person making a directive must be at least sixteen years of age and the directive must be witnessed by two people. The purpose of the *Act,* as with the Manitoba legislation, is to facilitate autonomy in decision-making for people and thus it is administratively simple. The *Act*, unlike the Manitoba *Act*, has a provision allowing for instructions with respect to the disposal of the maker's body after death.

(c) Ontario

The Ontario legislation is contained in the *Advocacy Act, 1992*, the *Consent to Treatment Act, 1992*, and the *Substitute Decisions Act, 1992.*[31] These laws, which also provide for adult guardianship and advocacy for vulnerable adults, are comprehensive and administratively more complex than those of Manitoba and Newfoundland. There are a number of procedural formalities that must be met before the advance health care directive is legal. The laws, although proposed in 1992, did not come into force until 1995 because of concerns about the costs and ease of implementation.[32] The new Ontario government plans to introduce a Bill this Fall to repeal the *Advocacy Act* and also plans to review the *Substitute Decisions Act* and the *Consent to Treatment Act*.[33]

The *Substitute Decisions Act* allows a person who is at least sixteen years old to grant a power of attorney for personal care and to limit the authority of the attorney with specific instructions. If the grantor gives no specific instructions, the attorney must ascertain whether the grantor expressed any wishes in another form and base his or her decisions on these wishes. If the wishes cannot be determined, the decision is made in the best interests of the grantor. Those who provide health or residential care, support or training for compensation cannot act as attorney unless they are also the grantor's spouse, partner, or relative. The power must be validated and registered by applying to the Public Guardian Trustee (PGT) with documentation of the power of attorney, assessments of the grantor's capacity, and a guardianship plan in the prescribed form. If this is not done, the power may only be exercised when an informed grantor does not object to a decision.

After the assessment, an advocate meets with the grantor to inform him or her of the following:

- the proposed validation;
- the statements of the assessors;
- the significance of the power of attorney; and
- the grantor's right to oppose the validation.

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[31] S.O. 1992, c.26, c.31, and c.30 respectively.

[32] *E.g.*, P. Crouch, "New *Advocacy Act* is Unaffordable, Unnecessary" (1994) 14:05 *Lawyers Weekly* 5; N. Diakun-Thibault, "Ontario's New *Advocacy Act* is Long Overdue" (1994) 14:19 *Lawyers Weekly* 5.

[33] M. Conrod, "Ontario Plans to Repeal *Advocacy Act*" (1995) 15:14 *Lawyers Weekly* 11.

The decision of the grantor as to whether he or she opposes the validation is to be promptly communicated to the PGT. If unopposed, the PGT will issue a certificate to the attorney specifying the powers the attorney has in relation to the personal care functions described in the *Act* to correspond with the opinions of the assessors. Where the PGT refuses to validate the power of attorney for personal care, and the attorney disputes the refusal, the PGT is required to apply to the court to decide the matter.

An expedited form of validation is provided for in the *Act*, where the grantor is assessed at a time when he or she is capable of providing for his or her own personal care. An application for registration may be made to the PGT by the grantor or the attorney with documentation of the power, and a statement by an assessor indicating the grantor's capacity and understanding of the effect of the power. The PGT then sends a copy of the application with documentation to an advocate. The advocate must then meet with the grantor and explain: the circumstances in which the power would be validated and the powers which the attorney would have; how the power may be revoked before and after validation; and that the grantor may object to the registration of the power.

The PGT must register the power once the advocate informs him or her that the grantor does not object, and the attorney is given a certified copy. The power is validated by having an assessor find the grantor incapable of performing the functions described in the *Act* in relation to personal care. The attorney provides a copy of the assessment and a guardianship plan to the PGT who will issue a certificate to the attorney indicating which functions the grantor is incapable of performing.

The *Consent to Treatment Act* recognizes the validity of an expression of wishes with respect to treatment when these are made while the person is capable. The manner of expression may be in a power of attorney, in a prescribed form, written, orally, or "in any other manner".

An application may be made to the Board by the decision-maker to depart from the wishes of the incapable person concerning consent to treatment where the incapable person, while capable, expressed a wish to refuse the treatment. The Board may only permit the departure from the grantor's wishes "if it is satisfied that the incapable person would probably, if capable, give consent because the likely result of the treatment is significantly better than would have been anticipated in comparable circumstances at the time the wish was expressed". The applicant must ensure that a rights adviser receives a copy of the application and any accompanying documentation. The rights adviser is obliged to meet with the incapable person and to explain the significance of the application, and the right to oppose it, as well as assist the person to obtain legal counsel if the incapable person so requests.

(d) Quebec

Quebec, like Nova Scotia in its *Medical Consent Act,* has a proxy model. The *Civil Code* provides for a comprehensive and enduring power of attorney, called a "mandate".[34] The mandate provides authority for a mandatary to make decisions relating to both the estate and the person.[35] The powers of the mandatary include acts necessary to ensure personal protection and the moral and physical well-being of the mandator, should he or she become unable to care for himself or herself.[36]

The *Civil Code* sets out a number of duties and obligations to which the mandatary will be held. Included among these is the general obligation to act in accordance with the mandate, and to act with prudence and diligence in performing it[37].

The *Civil Code* makes specific provision for a mandate for substitute consent to medical care. The mandatary may consent to medical treatment on behalf of a mandator who is incapable of giving or refusing consent to care.[38] When doing so, the mandatary is obligated to act "in the sole interest" of the person and to take into consideration, when possible, the person's wishes. He or she must also ensure that the care is beneficial, that it is advisable in the circumstances, and that the risks assumed are not disproportionate to the anticipated benefit[39].

The mandatary cannot give permission to have the incapable person admitted for a psychiatric examination if the person objects[40].

(e) British Columbia

British Columbia's Bill 48 *Representation Agreement Act* was introduced in the Legislature together with legislation on a new adult guardianship scheme in 1993. It is similar to the Ontario reforms in that it provides a comprehensive package of interrelated *Acts* and a structure to administer them. The *Representation Agreement Act* authorizes advance directives for both health care and financial affairs in the event that an adult becomes

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[34] *Civil Code of Quebec* (hereinafter C.C.Q.), S.Q. 1991, c.64, art. 2130.

[35] C.C.Q., arts. 2166-74.

[36] C.C.Q., art. 2131.

[37] C.C.Q., art. 2138.

[38] Where an adult who is incapable of giving consent refuses to receive care, the court will be required to authorize the substitute consent of the mandatary. Court authorization will not be required, however, in the case of emergency or hygienic care: *Civil Code*, art. 16. Court authorization will also be required where the mandatary is prevented, or refuses without justification, to give the consent.

[39] C.C.Q., art. 12.

[40] C.C.Q., art. 26.

incapable of making decisions independently. A representation agreement allows an adult to appoint a representative to make decisions on his or her behalf as well as to provide advance authorization for specific conduct such as physical restraint or the refusal of certain types of medical treatment including psychiatric treatment. The major problem with this Bill is the excessive formal requirements for the appointment of a representative.[41] These include that:

- the document state what each representative must do;
- each representative have a certificate, the failure of which can render the agreement invalid;
- a monitor be appointed or a statement be made that one is not required;
- there be two witnesses to validate the execution by the adult, each representative and alternate, all of whom must be present together;
- the agreement be registered; and
- set procedures be followed for either revocation or amendment of the agreement.

(f) Law reform initiatives in other provinces/territories

In addition to the laws that have already been enacted, there have been reform proposals by law reform and government agencies in three other provinces and one territory: Alberta, Saskatchewan, the Northwest Territories and New Brunswick.

A joint report of the Alberta Law Reform Institute and the Alberta Health Law Institute[42] supports the introduction of legislation recognizing advance health directives by both proxy and instruction directive. The draft legislation from that report proposes a statutory list of substitute decision-makers who would be consulted where a person has not made a directive. Legislation was introduced in the Alberta Legislature in 1994 but was not adopted by the end of the session. The Alberta Ministry of Health is accepting and analyzing public opinion before reintroducing legislation.[43]

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[41] On this issue the words of R.M. Gordon & S.N. Verdun-Jones, *Adult Guardianship Law in Canada* (Toronto: Carswell, 1992) are apt: "Too many safeguards and procedural impediments, however well-intentioned, could erode the right to self-determination and destroy the very purpose of this option", at 6-44.

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

[43] See *Report of the Special Senate Committee on Euthanasia and Assisted Suicide: Of Life and Death* (Ottawa: Ministry of Supply & Services, 1995) Appendix J. See also J. Mahony, "Alberta Considers New Legislation to Provide for Advance Directives" (1995) 15:14 *Lawyers Weekly* 112.

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".[44]

The Department of Health in the Northwest Territories and the Department of Justice in New Brunswick are also studying the issue of advance health care directives.[45]

C. Summary

A clear set of principles has emerged concerning the necessary reforms in adult guardianship legislation. In putting these principles into practice it is important to ensure that the law is accessible and affordable while giving the necessary protection to those subject to adult guardianship.

One of the ways of preserving the autonomy of adults who need a substitute decision-maker is to allow them to make decisions concerning health care and guardianship while they are still capable of doing so. Improved legislation on advance health care directives will be an important complement to adult guardianship legislation.

Legislation on advance health care directives can be relatively straight-forward with some legal safeguards in place to allow for cases where there is debate over a person's capacity, and for review of misconduct on the part of the substitute decision-maker.

The next Part will examine specific issues and will set out proposals for reform of the laws on adult guardianship and on advance health care directives.

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

[45] *Report of the Special Senate Committee on Euthanasia and Assisted Suicide: Of Life and Death* (Ottawa: Ministry of Supply & Services, 1995) Appendix J.

III RECOMMENDATIONS FOR REFORM

As was the case in Part II of this Report, the recommendations in this Part will deal with adult guardianship and advance health care directives separately. Section A deals with adult guardianship and Section B with advance health care directives. The recommendations are based on research carried out by the staff of the Commission with the assistance of the advisory group for each project. In addition, the Commission received thoughtful, helpful, and often detailed commentary from numerous people on some of the suggestions put forward by the Commission in both *Discussion Papers*. In general, the submissions supported the need for reform of the law in both areas and encouraged the Commission to urge the Government to respond to these concerns. There were also suggestions for related topics in need of reform which the Commission was encouraged to address. These included: the provision of services for people in need of psychiatric services (the committal procedures under the *Hospitals Act*), and the need to develop ways to better protect vulnerable adults (related to the *Adult Protection Act),* particularly in connection with economic abuse. The Commission felt that these were important areas for the government to consider for reform but decided that each would merit specific study in themselves.

There were several themes among the responses. First, that the right to personal autonomy should be reinforced and protected in the law. There were concerns that there be protection in place for adult guardianship to ensure that people were not exploited or harmed in this process and that there be strict limitations on any infringement of civil liberties; second, in both projects there was a concern that the system be accessible and at low cost to enable those who need assistance to get it; third, while people should have the right to refuse unwanted treatment, they should not feel pressured in a climate of decreased government spending on health care not to make use of resources because of their condition or because of their potential life span. These are difficult issues on which there are many views and perspectives, including the aboriginal view that a person's life is not something which is owned but rather is a gift. As a result, advance directives are irrelevant since a person's life cannot be controlled by another or by the state.[46]

The Commission has sought, in drafting the two *Acts* found at the end of this Report and in developing general recommendations, to provide a response to meet these concerns. The main recommendation of a majority of the Commission in this Report is that the Government of Nova Scotia consider and adopt the draft *Adult Guardianship Act* and the draft *Advance Health Care Directive Act* found at the end of this Report.

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[46] Comments of Joe B. Marshall, speaking to Victoria County Hospice Society on Aboriginal perspective on advance health care directives.

A. Adult Guardianship

1. The need for a law on guardianship

The first question to be asked is whether there is any need for a law on adult guardianship at all. Currently, there are laws in place which provide for adult guardianship: the *Incompetent Persons Act*, the *Inebriates Guardianship Act*, the *Hospitals Act*, the *Adult Protection Act,* as well as other options found in the *Powers of Attorney Act* and the *Medical Consent Act*. One option for reform would be to repeal the *Incompetent Persons Act* and *Inebriates Guardianship Act* and to not provide for any form of guardianship for adults at all.

Some people, such as a group representing mentally "disabled" adults called *People First*, believe that any form of adult guardianship is unacceptable. In their opinion, guardianship should never be a legal option since it discriminates against people and is a legal tool which takes away the freedom of people who have done nothing wrong. This group argues that fixing up old guardianship laws to make them more *Charter*-proof leads the public to believe that guardianship is acceptable. Many different mental health consumers agree with this approach and believe that other models which do not include any type of guardianship or substitute decision-making and which do not take away a person's right to decide should be explored.

Other people, however, see adult guardianship as a means of making it possible for people who may not be able to make legally binding decisions to participate in society. According to this view, guardianship is a means of enabling and assisting another person. Between these views is the view that adult guardianship is a "necessary evil" which should be used only as a last resort and only if other less restrictive ways of assisting an adult have been exhausted. This approach accepts that there are some people who will need someone else to make their decisions for them but that the law, as it presently exists, should limit the powers of guardians and should provide more safeguards for an adult subject to a guardianship application.[47]

The Commission proposed in the *Discussion Paper* that, on balance, a law on adult guardianship is necessary in Nova Scotia. However, a law on guardianship should reflect the values of personal autonomy and liberty of the person who may need assistance with decision-making. In this Report the Commission maintains this view in light of the responses received to the Commission's *Discussion Paper* and in light of the changes in laws elsewhere in Canada.

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[47] Support also comes from an international law document called the United Nations *Declaration on the Rights of the Mentally Retarded Persons* which states that everyone has the right to a guardian, if the need is there. UN GA Res. 2856 (XXVI, 2027d Mtg., December 20, 1971).

The Commission recommends that:

There be a Nova Scotia law which allows for the court ordered appointment of a guardian for an adult who needs one.

2. The need for reform

The second question that arises is whether the existing law needs to be reformed or altered or whether it is sufficient to meet current needs. The Commission stated in its *Discussion Paper* that the concerns identified with the *Incompetent Persons Act* and the *Inebriates Guardianship Act* were:

(a) Offensive language

With its origins in early English law, the *Incompetent Persons Act* still contains offensive language such as "idiot", "lunatic" and "incompetent". The language used to describe adults in need of guardians is important because public attitudes towards people in need of guardians may be negatively affected by such labelling. It is also difficult for family members who are attempting to help the situation to have a relative labelled an "incompetent". In addition, the words do not accurately describe a person's abilities. Although many people argue that all language will eventually become stigmatizing, there are less offensive ways to describe adults who are in need of guardianship services.

Adult guardianship legislation, which has been reformed in other provinces, does not define those who will be subject to a guardianship order but rather lists criteria that must be satisfied in order that a guardian be appointed. This approach has the advantage of avoiding labelling an adult in a global and inaccurate way. The draft *Act* presented in this Report abandons the use of the term "incompetent" and uses the terms "capable" and "capacity". The adult subject to guardianship is referred to as an "adult in need of a guardian".

(b) All-or-nothing approach

As mentioned above, the *Incompetent Persons Act* does not allow for the separate appointment of a guardian of the person and a guardian of the estate. There are usually no limits to the guardianship order so that most guardians have full powers to make most, if not all, decisions for the adult. Additionally, the assessment of "competency" under our law is an all-or-nothing approach. People are labelled as "competent" or "incompetent", without recognizing that people may be "competent" to make some decisions and not others. As well, people may be "incompetent" only some of the time. There are, of course, some examples of people who are totally unable to make decisions, such as a person in a persistent vegetative state but this is quite rare and most decision-making limitations are partial. In view of the principles of autonomy, respect and equality, this all-or-nothing approach is inappropriate.

(c) Emphasis on property

The focus of the *Incompetent Persons Act* is the protection of the property of the person. This historical emphasis on property is due, in part, to the belief that a guardian would instinctively know what to do for the adult. The *Act* does not say anything about what a guardian of the person should do or what his or her responsibilities should be. According to the wording of the *Incompetent Persons Act*, a court cannot appoint an estate guardian without appointing a personal guardian and *vice versa*. Although this defect has been remedied by the Supreme Court which does order separate appointments, it should be specifically provided for in the law. The Commission believes that guardianship of the person is just as important as guardianship of the estate and the law should spell out the responsibilities of guardians of the person.

(d) Lack of monitoring of guardians

The *Incompetent Persons Act* has few provisions for monitoring guardians except those that deal with the estate. Although the court may order that an estate guardian file an inventory, there is no particular time frame for this set out in the *Act*. In addition, although the initial passing of accounts must occur within one year, thereafter it is as the court directs. Furthermore, there is no provision in the *Act* for an interested person to intervene to ask the court to order that the guardian pass his or her accounts.[48]

(e) Paternalism: lack of respect and autonomy

The concept of "paternalism" is at the heart of guardianship law in provinces such as Nova Scotia, which continue to rely on the language and procedures of the early English law. Paternalism is drawn from an ancient English doctrine called "*parens patriae"* which gave the courts the right to interfere with children and "incompetents" for their own protection. This lack of respect for a person's autonomy is not in keeping with current values. Extensive intervention in the lives of people in need of guardians may not be in their best interests. The *Incompetent Persons Act* does not deal with the responsibilities of a personal guardian. This means that there is potential for undue interference in decisions about daily living and health care of the adult subject to the guardianship order. In the Nova Scotia law, a guardian has full powers unless they are limited in the court order. Given that incapacity is generally not global, this is inappropriate.

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[48] Lack of monitoring may also be a problem with the *Powers of Attorney Act*, R.S.N.S. 1989, c.352. See R.M. Gordon & S.N. Verdun-Jones, *Adult Guardianship Law in Canada* (Toronto: Carswell, 1992) at 3-127 for a discussion of this problem.

(f) *Charter* violations

Under the *Canadian Charter of Rights and Freedoms*, an adult has "the right to life, liberty and security of the person".[49] The appointment of a guardian results in the loss of fundamental rights and freedoms, particularly the right to security of the person. The *Charter* gives people the right to the least restrictive alternative when there may be a denial of their freedom such as when a guardianship order is made. Also, adults should have the right to "procedural fairness" before having a guardian appointed. The inadequacy of procedural safeguards is an area of concern with the *Incompetent Persons Act* and the way in which the law is applied. An adult may have difficulty opposing a guardianship application, because the proceedings are often complex, intimidating, and expensive.

Hearings themselves may seem to be lacking in procedural fairness in that the adult is usually not present or not represented by a lawyer. Medical evidence is often accepted without question, and medical practitioners are absent from court. Once a guardian has been appointed, the adult will have difficulty challenging the order by way of appeal or by seeking to revoke the guardianship order. Where a person no longer has control over his or her affairs, he or she may also lose the right to start a legal action and the "ability" to instruct and pay for a lawyer.

The *Charter* requires some basic procedural safeguards which should include the following:

- a fair and impartial hearing during which the person is entitled to full legal rights including the right to be notified of an application and hearing;
- the right to be represented at the hearing;
- the right to be heard at the hearing;
- the right to an interpreter;
- the right to call, examine and cross-examine witnesses;
- the right to review documents that are submitted to the court;
- the right to secure an adjournment of proceedings;
- the right to be informed of the outcome and the reasons for a decision; and
- the right to an appeal.

Many of these safeguards are available under the *Incompetent Persons Act* but it is extremely difficult for a person subject to a guardianship application to make use of them for a number of reasons, such as lack of knowledge about the legal system, a lack of support and assistance, and in some cases, inadequacy of financial assistance to hire a lawyer.

The same problems exist in connection with the *Inebriates Guardianship Act*. Given these problems with the legislation, the Commission is of the opinion that the existing laws should

[49] s.7.

be repealed and replaced with a new law which better reflects the values set out in the *Charter* and which meets current needs.

The Commission recommends that:

1. **The law in Nova Scotia, as it relates to the appointment of a guardian for an adult in need of one, be reformed;**

2. **The *Incompetent Persons Act* and the *Inebriates Guardianship Act* be repealed; and**

3. **The Government adopt the draft *Adult Guardianship Act* found at the end of this Report.**

3. The guiding principles of reform

Law reform in other provinces provides some guidance for reform in Nova Scotia. The main aim of a new law should be to balance the need for a simple and accessible means of enabling people to have decisions made for them with the need to protect their civil liberties which are at risk. In its *Discussion Paper*, the Commission set out a number of principles which it believes should be the foundation for any new law on adult guardianship:

- an adult's right to autonomy and self-determination;
- a presumption of competence;
- guardianship as a last resort;
- guardianship order should be the least restrictive one possible; and
- wishes of the adult to be taken into account.

There was support for these principles in the submissions and a suggestion that a right to representation be added as a principle. In its *Discussion Paper*, the Commission suggested that "a person subject to a guardianship application should have an opportunity to hire a lawyer for independent legal advice and if there is not enough money in the estate, a government sponsored or legal aid lawyer should be made available to the person".

Adult guardianship legislation in other provinces does not provide for paid legal services except in Quebec. There, a judge or prothonotary may order that an adult be represented and that the cost be paid. In Alberta, the legislation does not provide for paid legal service, however, this may be done on an informal basis. According to one source, the "use of private guardianship was encouraged by arranging for costs to be paid by the office of the public guardian when it was a hardship....".[50]

[50] J.R. Christie, "Guardianship in Alberta, Canada", in T. Apolloni & T.P. Cooke, eds. *A New Look at Guardianship* (Baltimore, Paul H. Brookes, 1984) c.12.

Submissions in response to the *Discussion Paper* on this point suggested that the provision of paid legal service would be too costly for the government. Others suggested that the procedural safeguards suggested in the *Discussion Paper* pointed to a perceived adversarial nature of a guardianship application which is often not the case.

In view of the submissions, the Commission supports the view that an adult, subject to a guardianship application, should have a right to be represented but that it not be mandatory to provide a paid lawyer. However, in order to ensure procedural fairness, the adult should be informed of his or her right to representation and his or her need for a guardian should be appropriately assessed before proceeding with an application.

The following briefly outlines the Commission's views on principles that should be incorporated into the law and how they may be implemented:

(a) All adults have a right to autonomy and self-determination such that guardianship should be used only as a last resort.

The law should recognize that people have the right to make their own decisions, that is, they have a right to autonomy and to self-determination. These rights mean that every capable adult should be allowed to make decisions even if others may not understand or agree with the decisions. An important aspect of ensuring that an adult's right to autonomy and self-determination are protected is to have a system with procedural safeguards and monitoring.

It was noted above that the Commission recognized the need to support a person's right to procedural safeguards. At the same time, the Commission is aware that it is important not to make the process so administratively difficult that people will not seek guardianship when it is needed. The Commission has concluded that the appropriate approach is to provide for public supported monitoring and other procedural protections for individuals and, at the same time, avoid the high administration costs found in the Ontario system.

The draft *Act* proposes the creation of an Office of the Public Guardian to act in combination with the Office of the Public Trustee.[51] This expanded office would be responsible for screening applications and for ensuring that the subjects of the applications have been informed of their rights and the effect that such orders could have on them. In addition, this Office would have the role of monitoring guardians of the estate. As noted earlier, Nova Scotia currently has no advocacy system in place to ensure that people, at a minimum, are informed of their rights. Monitoring of estate guardians is inadequate and there is no monitoring of personal guardians.

[51] Concerns were expressed by the Public Trustee about the need for increased resources to fulfil this role.

Under the draft *Act,* the Office of the Public Guardian-Trustee would:

- provide advice and information on adult guardianship to the general public and professionals;

- screen applications for guardianship to ensure that the adult who is the subject of the application has been informed of its implications; that the adult is aware of his or her right to a hearing and to be represented; and that documentation is complete;

- monitor personal as well as estate guardians; and

- ensure that an adult in need of a personal guardian who has no one willing or able to act for him or her receives the appropriate services and care through the Ministry of Community Services.

Since guardianship of the person is a personal relationship, the Public Guardian-Trustee will not act as personal guardian. However, the Office will ensure that a person in need receives the community resources necessary to fulfil his or her needs. The Public Guardian-Trustee will maintain the role of giving consent under the *Hospitals Act* where there is no other person willing or able to do so and will act as guardian of the estate under the *Hospitals Act* and the *Adult Protection Act*.

The Office of the Public Guardian-Trustee will receive notice of all guardianship applications and will make the application where there is no one willing or able to do this. It will also arrange for an assessment of the adult subject to the application (if the applicant has not established that one is not required) and will apply for the automatic review of the guardianship order as required under the draft *Act* if the guardian does not do so.

The monitoring role includes receiving and reviewing annual reports on the management of property, and holding the property in trust if the guardianship order ends. The standard of care of estate guardians has been expanded to provide a more detailed description of an estate guardian's obligations. Under the draft *Act*, the guardian of the estate must: give the Public Guardian-Trustee a list of all the real and personal property of the adult and its value within six months; faithfully manage the estate for the best interests of the adult; report to the Public Guardian-Trustee annually from the date of the order on how the property has been managed; and, in the event that the guardianship ends, put all of the adult's property in trust with the Public Guardian-Trustee. Other obligations with respect to investments are listed in section 23 of the draft *Act*.

Complaints about how a guardian is carrying out his or her duties will go to the Public Guardian-Trustee who will investigate the complaint and apply to the court for review of a guardianship order if warranted. The court can then remove the guardian if the criteria set out in the draft *Act* are satisfied.

The court will be provided with a statement of intent as to how a proposed guardian will provide support and assistance to an adult in need of a guardian. This statement, which will form part of the order to be monitored by the Public Guardian-Trustee, may be used as a yardstick against which to measure the guardian's subsequent conduct.

A number of additional safeguards are incorporated into the draft *Act* to protect the autonomy of the adult. Section 6 sets out a list of those who will be informed of the application and who will have a right to participate in the hearing. Giving notice to any person with an interest in the application will help to ensure that the adult's interests are protected. The nearest relative who will receive notice includes a spouse or partner, defined to include a person of the same or opposite sex. Service of notice to the adult who is the subject of the application cannot be dispensed with unless the court determines that it would be futile or harmful to the adult.

When the adult is being assessed, the assessor must allow a friend or representative of the adult, if available, to help the adult understand the purpose and consequences of the assessment and the assessor may not conduct the assessment unless the adult subject to the application consents. However, at the hearing, the court will be able to order an assessment on an adult who has refused an assessment if the adult is in danger of abuse, neglect or self-neglect. It should be noted that in these circumstances the *Adult Protection Act* could be used instead of the draft *Adult Guardianship Act* to get an order to have an adult assessed. This means that the two *Acts* need to be harmonized to ensure that both have the same procedural safeguards for the adult subject to such an order.[52]

(b) An adult who is the subject of a guardianship application should be presumed to be capable of making decisions about his or her health care, personal care and well-being, and financial affairs until the contrary is clearly demonstrated.

The adult who is the subject of a guardianship application will be presumed capable of instructing counsel and the applicant will have the burden of showing that the adult is in need of a guardian. This means that in the guardianship application, the applicant must set out the reasons he or she believes the adult subject to the application is in need of a guardian, and the extent of this need.

(c) The assessment of the capacity of an adult should take into account the circumstances of the adult, the kinds of decisions the adult must make, the adult's way of communicating, and the available support and resources.

The Commission received submissions on the standards to be used in assessing when a person is in need of a guardian. After considering these submissions, the Commission

[52] As mentioned in Part II of this Report, elder abuse legislation is the subject of a research project by the Health Law Institute of Dalhousie University, Halifax.

concluded that there should be list of issues set out in the *Act* that the judge should consider in making the determination as to whether a person is in need of a guardian and in deciding the extent of assistance required. A formal assessment of whether a person is in need of a guardian will be multidisciplinary, comprehensive, and include interviews with family, friends and caregivers to determine the ability of the adult, with or without help, to understand relevant information and to make and communicate decisions concerning health care, nutrition, shelter, clothing, hygiene, and safety if the application concerns personal guardianship, and financial affairs if the application concerns estate guardianship.

Since the adult may be capable of making decisions in one area and not another, the law will provide for the separate appointment of a "guardian of the estate" and a "guardian of the person".[53]

(d) The court should not appoint a guardian unless alternatives, such as providing support and help, have been tried or carefully considered.

In determining whether or not guardianship is appropriate, the *Act* provides that the court must ask whether other less restrictive options have been considered or tried for the adult. This is an important guiding principle because even a partial, time-limited guardianship order will have a dramatic impact on the adult's life. The reality is that people will tend to scrutinize all of the adult's decisions since "the law" has already decided that help is needed in some areas of decision-making.

The Commission noted in its *Discussion Paper* that there are many practical issues which arise from the adoption of this principle of guardianship as a last resort which include: How can a court know when another less restrictive option is workable? Should the person bringing the application be required to show that less restrictive options have been tried? If the court decides that a less restrictive option is available, should it review the matter later to see if it is working? Who should seek this type of review?

The Commission considered these questions and in the draft *Act*, the applicant is required to set out in the application the alternatives to guardianship that have been considered. The Public Guardian-Trustee in screening the application will ensure that this and other principles were followed, and the court will not appoint a guardian unless it is satisfied that it would be consistent with the principles.

(e) A guardianship order should be the least restrictive one possible.

Most adults who need a guardian are able to make some legal decisions for themselves and the Commission believes that they should be encouraged to do so. "Competency" is not a

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[53] The separate appointment of a guardian of the estate and the person is also consistent with the regime for registered Mi'kmaq in the province. Currently, the federal *Indian Act,* R.S.C. 1985, c.I-5, governs guardianship of the property of registered band members, whereas provincial law governs guardianship of the person.

global concept and people often have areas of their lives where assistance is not needed. Guardianship orders should be designed to reflect this. A guardianship order should be personalized and it should be the least restrictive one for the individual. The order should focus on the adult's abilities, allowing the person to participate as fully as possible in as many areas of decision-making as possible. Making partial guardianship the usual practice rather than the exception will help to ensure that an order is the least restrictive one possible.

An assessment will normally occur before the court application, unless it is established that a formal assessment is unnecessary. This has the advantage of ensuring that if an order is needed, it can be designed to be the least restrictive one possible. The statement of intent of the proposed guardian can be assessed to ensure that it is the least restrictive plan possible. The choice of guardian is also important in ensuring that the order will be carried out in the least restrictive way possible. In most provinces and territories there is no guidance for the court as to who will be the best guardian for the adult in need. The Supreme Court of Nova Scotia has, however, stated that in selecting a guardian the primary concern is the interests of the adult over and above those of the family or kin.[54] The draft legislation requires that the proposed guardian act in the best interests of the adult in need of a guardian.

The court will limit the authority of the guardian to include only what is necessary to assist the adult in need of a guardian. Furthermore, the *Act* provides a list of areas of decision-making which the court must specify as falling within the authority of the personal guardian, otherwise the guardian will not have the authority. Furthermore, there are limitations set out in subsection 18(c) of the *Act* on what a personal guardian cannot consent to without the court's approval. These limitations include sterilization which is not medically necessary, as well as placement of the adult in a psychiatric facility. The Commission was concerned about giving a guardian powers which may deprive a person of fundamental liberties and, as a result, require that a court give specific, additional consideration to these issues. In an effort to reduce court costs, however, the draft *Act* foresees cases where the court may grant approval for one of these additional powers at the original guardianship hearing if there is sufficient evidence that the additional power should be given.

Another measure to restrict an order of guardianship is for the court to indicate the extent and duration of the guardian's authority and the time at which there will be a periodic review of the order. The Commission received several suggestions on this issue. Some were concerned with abuse and recommended frequent reviews. Others were concerned with the cost to the person's estate, the inconvenience, and the distress if the reviews were too frequent. After considering these views, the Commission recommended that a review take place at least every three years, or more often as ordered by the court, and at any time on application.

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[54] *Re Barnhill* (1970), 3 N.S.R. (2d) 488 (T.D.).

(f) The wishes of the adult in need of a guardian should be taken into account in an order of guardianship.

In the draft legislation, a determination of the adult's wishes will be made in the assessment to ascertain whether the adult showed a preference for or a rejection of a particular guardian. Secondly, the list of those who will receive notice of an application for guardianship and who will have a right to participate includes those who are likely to have knowledge of the adult's wishes such as an attorney in an enduring power of attorney or the person appointed under an advance health care directive.

Consideration of the adult's wishes as to the person to be appointed as guardian is frequently recognized by the courts despite the absence of a statutory duty to do so.[55] In the draft *Act*, the court will inquire as to the wishes of a person who is the subject of a guardianship application. It will then be a matter for the judge to decide the weight to give to the wishes in light of the assessment as to the needs of the adult.

The draft *Act* provides that the court is also expected to inquire as to any wishes expressed orally while capable or in an advance health care directive by the person who is the subject of the application and any current wishes of the person when this is possible. The draft *Act* provides that the courts should respect the adult's wishes to have a proxy in an advance health care directive act as personal guardian and an attorney in an enduring power of attorney act as estate guardian unless the court finds them unsuitable according to the criteria set out in the *Act*.

Before appointing a guardian, the court must be satisfied that the guardian will respect the wishes the adult made while capable and will respect, as much as possible, the current wishes of the adult in need of a guardian. An issue which arises from this is whether the guardian should be required to decide as if he or she was that person or whether the guardian is to make the decision of the basis of his or her view as to the best interests of the person. As set out in the draft *Act* the guardian must follow clearly expressed wishes made by the adult in need of a guardian while the adult had capacity; act in the best interests of the adult if there are no earlier wishes known; and consider current wishes of the adult in need of a guardian that are in the adult's best interests. This means that only when the adult's previous wishes are not known, will guardians be allowed to decide on the basis of their own views as to the best interests of the adult.

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[55] *E.g.*, *Re Cochrane* (1964), 47 W.W.R. 669 (Sask. Q.B.) at 674; *Re West* (1978), 20 N.B.R. (2d) 686 (C.A.) at 709.

The Commission recommends that:

A law on adult guardianship reflect the following principles:

1. **All adults have a right to autonomy and self-determination such that guardianship be used only as a last resort.**

2. **An adult who is the subject of a guardianship application be presumed to be capable of making decisions about his or her health care, personal care and well-being, and financial affairs until the contrary is clearly demonstrated.**

3. **The assessment of the capacity of an adult take into account the circumstances of the adult, the kinds of decisions the adult must make, the adult's way of communicating, and the available support and resources.**

4. **The court not appoint a guardian unless alternatives, such as providing support and help, have been tried or carefully considered.**

5. **A guardianship order be the least restrictive one possible.**

6. **The wishes of the adult in need of a guardian be taken into account in an order of guardianship.**

4. Implementation of the principles of reform in the draft *Act*

A number of components of the proposed law on adult guardianship have already been outlined in discussing the principles of reform. The following is a summary of specific provisions in the draft *Act* that reflect each of the principles and recommendations of the Commission.

(a) The right to autonomy and self-determination

The Commission recommends that:

1. **A new Office of the Public Guardian be established in combination with the Office of the Public Trustee to provide advice and information on adult guardianship to the general public and to professionals, to screen applications, to monitor guardians, and to ensure that adults without a personal guardian receive the appropriate services.**

2. **The Public Guardian-Trustee in screening applications ensure that the adult is independently informed of the implications of the application and his or her right to representation.**

3. **The proposed guardian provide the court with a statement of intent as to how he or she will provide support and assistance to the adult in need of a guardian which will be used to measure the guardian's subsequent conduct.**

4. **Notice of an application to appoint a guardian be sent to a wide variety of individuals to ensure that the adult's interests are protected.**

5. **The person assessing the adult's needs allow a friend or representative of the adult, if available, to explain the purpose of the assessment and not conduct an assessment unless the adult consents.**

(b) Presumption of capacity to make personal, health care, and financial decisions

The Commission recommends that:

1. **An adult who is the subject of a guardianship application be presumed capable of instructing counsel.**

2. **The applicant be required to set out the reasons he or she believes the adult subject to the application lacks capacity and the extent of the alleged incapacity.**

(c) Assessment of capacity to be personalized

The Commission recommends that:

1. **The assessor evaluate the present and projected needs of the adult and the ability of the adult to understand relevant information and to make and communicate decisions concerning specific tasks.**

2. **The assessment be multidisciplinary, comprehensive and, where possible, involve interviews with family, friends, and caregivers.**

(d) Guardianship order the least restrictive one possible

The Commission recommends that:

1. **The applicant be required to set out in the application alternatives to guardianship that have been considered.**

2. **An assessment of the adult subject to the application be done before the court application unless the adult refuses consent or it has been established that one is unnecessary.**

3. **The court limit the authority of the guardian to include only what is necessary to assist the adult in need of a guardian.**

4. **The order be for a limited duration at which time the order will be reviewed.**

5. **Review of an order take place at least every three years and at any time on application.**

6. **The court assess the proposed guardian to ensure that he or she will act in the best interests of the adult.**

7. **The guardian have a duty to limit his or her interference into the life of the adult as much as possible and to encourage the adult to take part in decision-making as much as possible.**

8. **Any interested person who considers that a guardian is failing to carry out his or her responsibilities or is doing so improperly or in contravention of the terms of the order be able to file a complaint with the Public Guardian-Trustee.**

(e) Wishes of the adult in need of a guardian taken into account

The Commission recommends that:

1. **The assessment ascertain whether the adult shows a preference for or a rejection of a particular guardian.**

2. **The attorney appointed under an enduring power of attorney and a proxy appointed in an advance health care directive be notified of a hearing so that they can reveal what they know of the adult's wishes.**

3. **The court inquire as to the wishes of the adult subject to the application and respect the adult's wishes to have an attorney or proxy act as guardian unless the court finds them unsuitable according to the criteria set out in the *Act.***

4. **The court be satisfied before appointing a guardian that he or she will respect the wishes made by the adult when capable and will respect, as much as possible, the current wishes of the adult.**

5. **The guardian be required to follow clearly expressed wishes made by the adult while capable; act in the best interests of the adult if no earlier wishes are known; and consider current wishes of the adult that are in the adult's best interests.**

B. Advance Health Care Directives

1. There is a need to reform the law in Nova Scotia to allow a variety of options for people to make an advance health care directive.

Medical technology has now progressed to the stage where people who develop medical problems can be kept alive longer than ever before. For many people, the concept of a "natural death" may no longer exist because technology can extend the life of the person well beyond the point at which they may have died without intervention.

Many people experience these issues directly when a difficult decision has to be made by family and friends, with respect to withdrawing life support for a loved one who has 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 since most unwanted medical intervention occurs during the last weeks of a person's life. Often families and health care providers feel obliged, ethically and legally, to do everything possible to preserve life, even if the person would not

have agreed to the intervention. In addition, people may have an unforseen accident or illness which makes them unable to consent to treatment or the withdrawal of treatment. This leaves the family or health care providers in the position of having to make treatment decisions without guidance from the person.

The law has not always responded quickly to these difficult ethical issues and this *Final Report* 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 Report describes the law as it presently exists in Nova Scotia and sets out a number of the Commission's suggestions on ways the law could be changed to better meet the needs of Nova Scotians.

It is an accepted 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.[56] 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, a physician may be obliged to follow a person's prior instructions with respect to the refusal of medical treatment. For example, in the case *Malette* v. *Shulman*[57] 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 view 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 Ontario case *Fleming* v. *Reid and Gallagher*[58] where the court agreed with the importance of the right to self-determination in a case involving an advance refusal of psychiatric health care.

A physician who treats a patient against his or her wishes or without an informed decision to have treatment may be found by a court under the common law to have committed what is called a "battery". Treatment without consent may also be considered a criminal assault under the *Criminal Code of Canada*.[59] At the same time, there is a general duty to continue an act, once undertaken, if stopping the act may be dangerous to life. In 1982, the Law Reform

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

[57] (1990), 67 D.L.R. (4th) 321 (Ont. C.A.).

[58] (1992), 48 O.A.C. 46.

[59] R.S.C. 1985, c.C-46 [hereinafter the *Criminal Code*].

Commission of Canada[60] 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 recent *Report of the Special Senate Committee on Euthanasia and Assisted Suicide,*[61] while not supporting the practice of euthanasia or assisted suicide, recommended that the provinces and territories which do not have a law allowing for advance health care directives adopt such laws and recognize advance directives made in other provinces and territories. Their view was that "if the process of preparing and executing such documents is clear, straightforward and available at minimal cost, more people will be encouraged to complete advance directives."[62]

It is important to understand the difference between advance directives and assisted suicide. Advance directives allow you to do what is legal and cannot direct someone to do something that is illegal. In light of the decision of the Supreme Court of Canada in *Rodriguez* v. *British Columbia* [63] it is clear that assisted suicide is not legal in Canada. Any direction in an advance health care directive to carry out an act which would constitute assisted suicide could not lawfully be followed. The practical distinction between withdrawal of treatment, which is legal, and assisted suicide, which is not, is not entirely clear. To remedy this, the Senate Report recommends changing the *Criminal Code* "to explicitly recognize and to clarify the circumstances in which the withholding and withdrawal of life-sustaining treatment is legally acceptable" and that there be a national campaign to inform the public as to their rights concerning refusal of life-sustaining treatment.

Part II described the existing law in Nova Scotia, the *Medical Consent Act,* which allows for one type of advance health care directive in Nova Scotia. The issue for the Commission was whether this law needs reforming or whether it was sufficient.

In the *Discussion Paper* the Commission suggested that the form of advance health care directive in the *Medical Consent Act,* while useful for many people, did not meet the needs of everyone and that a broader range of alternative forms of advance health care directives should be available.

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

[61] *Of Life and Death* (Ottawa: Ministry of Supply and Services Canada, 1995).

[62] *Of Life and Death*, at 50.

[63] [1993] 2 S.C.R. 519.

Comments received in response to the *Discussion Paper* have endorsed this view. It was clear from the public response to the *Discussion Paper, Living Wills in Nova Scotia* that there was strong support for a change in the law to allow for a variety of options for advance health care directives.[64] The fact that laws are being passed in other provinces to allow for a range of directives also supports the need for reform. A majority of the Commission support the need for the draft *Advance Health Care Directives Act*. Commissioner Forgeron, however, strongly opposes the use of any type of advance directive. Her dissenting opinion is found at the end of Part IV on page 56.

The *Discussion Paper* suggested that these include the instructive model (commonly known as the living will), the proxy model, and a combination of both. In addition, for individuals who had not made a directive, the law should include a statutory list of those who would be a person's substitute health care decision-maker. In response to public input, the instructive directive was expanded to allow a person to write either specific instructions or general principles to be followed in making decisions on his or her behalf. This option is included in the draft *Act* as has been done in the recent Newfoundland legislation.

Although the *Medical Consent Act* requires that a person must be an adult, that is, nineteen years of age, this is inconsistent with the common law position that a person should not have to be an adult in order to make medical decisions. In the *Discussion Paper*, the Commission suggested that a capable person who is sixteen years of age or older should be allowed to make an advance health care directive. There was general support for this in the submissions the Commission received which is also consistent with the law in Manitoba, Newfoundland and Ontario. There is an additional requirement that the individual be capable of understanding relevant information and the consequences of choosing one or another health care option. However, there is no requirement to prove capacity.

[64] Workshop organized by the Disabled Persons Commission on Adult Guardianship and Living Wills, April 24, 1995; Victoria County Hospice Society, Workshop, June 7, 1995; Canadian Pensioners concerned, *Resource Package on Living Wills*, 1995; D.-M. Sonnichsen, "Schizophrenia Society Seeks New Living Wills Legislation" *The Chronicle Herald* (28 April 1995) A9.

The majority of the Commission recommends that:

1. The law in Nova Scotia be reformed to permit a capable person who is sixteen years of age or older to make a wider range of advance health care directives and that the Government adopt the draft *Advance Health Care Directives Act* found at the end of this Report to replace the *Medical Consent Act*.

2. Advance health care directives be included in the law to:

(1) allow a person to set out instructions or general principles about future health care decisions to be made on the maker's behalf;

(2) appoint a proxy to follow instructions and interpret the general principles concerning health care decisions set out in a directive;

(3) appoint a proxy to make health care decisions on the maker's behalf.

2. An advance health directive should be effective whenever people are unable to make health care decisions for themselves.

Legislation from most other provinces on health care directives defines health care broadly. This is the approach taken in the draft *Act* which defines a health care decision to include consent, refusal or withdrawal of consent to health care including prevention, examination, diagnosis, treatment, and palliation of mental or physical disease, ailment, or disability. The *Act* also allows a person to appoint a proxy to make personal decisions such as choice of residence but *only* if stipulated in the directive. In this way, a proxy could be given broad decision-making authority similar to what a guardian of the person would have under the draft *Adult Guardianship Act*.

The Commission had a number of submissions on the situations in which an advance health care directive should become effective.[65] The issue is whether a directive should be available only in cases of terminal illness or whenever the maker is unable to make a health care decision. In the *Discussion Paper*, the Commission suggested that an advance health care directive should be effective whenever a person is no longer capable of making a health care decision for him or herself. This would include those with periodic illnesses such as schizophrenia and manic depression. The *Hospitals Act* provision on committal would still apply but the directive would allow an individual when capable to give consent to treatment for future episodes of incapacity before the person became a danger to themselves or to others. This is the approach adopted in most other provinces and a majority of the Commission recommends this approach as respecting autonomy in health care decisions.

[65] *E.g.*, submissions from the Schizophrenia Society of Nova Scotia and Connections Clubhouse, Camp Hill Medical Centre.

The majority of the Commission recommends that:

1. **A health care decision include consent, refusal or withdrawal of consent to health care including prevention, examination, diagnosis, treatment, and palliation of mental or physical disease, ailment, or disability.**

2. **A proxy can make personal decisions on behalf of the maker if specifically given authority in the directive.**

3. **An advance health care directive be effective whenever a person is unable to make health care decisions.**

3. The law on advance health care directives should have few formal requirements to ensure that a person's wishes are respected and that the costs of making a directive are low.

An adult's right to self-determination means that he or she has a right to consent or refuse health care while competent. An advance health care directive permits a capable individual to do this in anticipation of future incapacity. Formalities in making a directive may ensure that makers have given due consideration to all of their options and may alert others to the fact that they have a directive. On the other hand, formalities may discourage people from exercising this option because of inconvenience and cost. The Commission is of the view that a law with few formal administrative requirements will best meet public needs.

There are a number of samples of living wills documents which have been proposed.[66] Both the Manitoba and the Newfoundland laws say that a particular form should not be mandatory but they allow for regulations as to a suggested form. The British Columbia Bill likewise does not require a particular form. The Commission's draft *Act* adopts this approach but includes a suggested form adapted from the Law Reform Commission of Manitoba's report as a schedule to its draft *Act*.

If a person's wishes as to health care are to be respected, it is important that health care providers be aware of an advance directive before they treat, especially in an emergency where there is a duty to treat. One way of doing this would be to require that notification of the existence of a directive be given to health care providers. Another is to require that a directive be formally registered. The draft *Act* in this Report does not require that the maker communicate its contents to a health care provider and neither notification nor registration

[66] *E.g.*, *Self-Determination in Health Care (Living Wills and Health Care Proxies)* (Winnipeg: Manitoba Law Reform Commission, 1991) at 51; W. Molloy & V. Mepham, *Let Me Decide* (Toronto: Penguin, 1992); P. Singer, Bioethics Centre, Toronto; and the organization, Dying with Dignity, Toronto; J.A. Yogis, R.R. Duplak & J.R. Trainor, Sexual Orientation and Canadian Law: An Assessment of the Law affecting Lesbian and Gay Persons, Research Report prepared under a grant from the Federal Department of Justice Human Rights Research Fund, 1995 (copy on file with Commission).

are required. Health care providers, however, have a duty to inquire about the existence of a directive.

Because of advances in medical technology, it is advisable for a person with an advance health care directive to inform family, friends, and health care providers of its existence and to update it. The problem with requiring periodic update is that a person may forget to do so and the directive could be invalid. As in the Manitoba, Ontario and Newfoundland laws, the draft *Act* does not require that a directive be periodically renewed.

The majority of the Commission recommends that:

1. **The law reflect the principle of autonomy and its purpose be to allow a capable individual a simple means of making health care decisions in the event that he or she is no longer capable of doing so.**

2. **There be no mandatory form for an advance health care directive but that the *Act* include a sample document to show people the types of issues they should be considering.**

3. **There be no formal requirement for registration or notification about the existence of an advance health care directive.**

4. **Although periodic renewal of an advance directive is desirable it not be mandatory.**

4. The law should include a statutory list of health care decision-makers for those who have not made an advance health care directive.

If a person fails to make an advance health care directive or fails to appoint an alternate proxy and has a proxy who is unable to act, there may be a need for someone to make health care decisions on their behalf. The joint report of the Alberta Law Reform Institute and the Alberta Health Law Institute[67] approached this problem by including a statutory list of individuals who may be called upon to do this. Such a statutory list was adopted in the Newfoundland legislation. This approach has been adopted in the draft *Act* in this Report with one important change. The first person on the list in the Alberta draft law and the Newfoundland law is the person's spouse. The draft *Act* in this Report adds "or partner" and defines partner in the draft *Act* to include a same-sex partner. This change is in response to submissions received by the Commission in support of the proposal in the *Discussion Paper*

[67] *Advance Directives and Substitute Decision-Making in Personal Health Care* (Edmonton: Alberta Law Reform Institute, Report No. 4, March 1993).

to expressly include common law or same-sex partners and it is consistent with the *Human Rights Act* of Nova Scotia which prohibits discrimination on the basis of sexual orientation.[68]

The draft law from Alberta recommended that people be allowed to name anyone who they would **not** want to act as their statutory proxy. This provision has also been adopted in the draft *Act* in this Report.

The majority of the Commission recommends that:

1. **If a person has not made an advance health care directive and does not have a guardian with authority to make health care decisions, there be a statutory list from which a substitute health care decision-maker can be appointed statutory proxy.**

2. **The maker of a health care directive be allowed to specify who is not to act as his or her statutory proxy.**

5. No presumptions should arise from the fact that a person has not made an advance health care directive or has revoked one.

Concern was expressed in testimony before the *Special Senate Committee on Euthanasia and Assisted Suicide*[69] that someone who did not have a living will or who revoked one might be presumed to want all possible treatment. Both Manitoba and Newfoundland have a provision in their legislation to the effect that the absence of a directive will not give rise to any presumptions. This provision has been adopted in the draft *Act* in this Report.

The majority of the Commission recommends that:

No presumption arises from the fact that a person has not made an advance health care directive or has revoked one.

[68] R.S.N.S. 1989, c.214, as am., ss.5(1)(n). See also, J.A. Yogis, R.R. Duplak & J.R. Trainor, *Sexual Orientation and Canadian Law: An Assessment of the Law affecting Lesbian and Gay Persons,* Research Report prepared under a grant from the Federal Department of Justice Human Rights Research Fund, 1995 (copy on file with Commission).

[69] *Of Life and Death* (Ottawa: Minister of Supply and Services Canada, 1995) at 49.

6. A person with capacity should be able to revoke an advance directive by making a later directive or a document stating that the directive is revoked, or by destroying the directive or directing someone else to destroy it.

It is important that in a matter involving personal autonomy and self-determination that people be able to change their mind about a directive and revoke it if they wish. The Commission is of the view that a person must have capacity in order to revoke an advance directive because if not, the person would no longer be in a position to execute another directive due to lack of capacity.

Furthermore, the Commission recommends that revocation should be considered 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.

In keeping with the Commission's philosophy of minimal legal formalities, there should be no requirement that the person give formal notice to anyone upon revocation (as is the case in Ontario and British Columbia).

Both the Manitoba and the Newfoundland legislation have a clause stating that a directive is automatically revoked on divorce. In its *Discussion Paper*, the Commission took the view that as is the case with a will dealing with property, individuals should be responsible for ensuring that the appropriate changes are made in their legal documents on dissolution of marriage. The Commission was also concerned about any position which automatically terminated an appointment. There is a division of opinion among the Commission about this issue. While some agreed with the policy put forward in the *Discussion Paper*, others felt that it could be problematic if a person divorces but does not change a directive and the ex-spouse is called upon for health care decision-making. On balance, a majority of Commissioners concluded that an advance directive appointing a spouse as proxy would be void upon divorce.

The majority of the Commission recommends that:

An advance health care directive be revokable if a person has capacity and that it 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.

7. A person should be able to name any number of alternate proxies but joint proxies should not be allowed.

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 after the person is incapable of making health care decisions, everything should be done to ensure that this is

accomplished. For example, if more than one proxy is named, then if one proxy dies there is another to act. This can be accomplished by allowing for alternate proxies or, as is done in some jurisdictions, by allowing joint proxies. However, if joint proxies are allowed, the legislation must be clear about what will happen if there is a conflict between proxies.

Nova Scotia's *Medical Consent Act* does not explicitly state that more than one proxy may be named and the singular is used to refer to the designate. Technically, one can argue it does not preclude having more than one proxy since the *Interpretation Act*[70] says that the singular includes the plural.

Other provinces have recognized the need for more flexibility in the appointment of proxies. The Manitoba and Newfoundland legislation allow for more than one proxy and they are deemed to act successively, rather than jointly, unless the directive says otherwise. Both jurisdictions set rules for the resolution of disputes between joint proxies.

The Commission has decided against joint proxies on the basis that there is too much potential for disagreement and delay in making health care decisions. The draft *Act* does, however, allow any number of alternate proxies. An alternate proxy would act if the first dies, is no longer competent to act, refuses to act or is unavailable to act.

The majority of the Commission recommends that:

A person 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. However, joint proxies should not be allowed and, where more than one is named in a directive, they should be presumed to act in succession.

8. A person who has reached the age of nineteen years of age should be presumed capable of acting as proxy.

In its *Discussion Paper,* the Commission suggested that a proxy be sixteen years of age or older. There were a number of responses from the public with the opinion that sixteen was too young and that a proxy should be the age of majority. None of the provinces except Ontario allows for a proxy to be as young as sixteen years. The Commission has accepted the view in the draft *Act* that a proxy should be the age of majority.

[70] R.S.N.S. 1989, c.235, as am.

The majority of the Commission recommends that:

A capable person who has reached the age of nineteen years be presumed capable of acting as a proxy and there be no other restrictions on who can act as proxy, such as ones based upon whether they will benefit from inheritance or an insurance policy from the maker.

9. A proxy should not be compelled to act and should be protected from liability if he or she acts in good faith according to the draft *Act*.

In its *Discussion Paper*, the Commission suggested that if people did not have the option of changing their minds about acting as proxies they might be reluctant to accept the role. In Ontario, an attorney under a power of attorney for personal care must resign in writing and must notify a number of individuals. The Newfoundland legislation requires that the proxy accept the appointment in writing but does not address the question of resigning. The Manitoba and Newfoundland legislation specifically exempt a proxy from liability for failing to make health care decisions on behalf of the maker and this provision has been incorporated into the draft *Act* in this Report.

There may be disagreement among the family or friends of an individual about the decisions made by the proxy. A proxy who accepts the responsibility of this office should be exempt from liability so long as he or she acts in good faith according to the rules set out in the law. The provision to this effect, found in both the Manitoba and the Newfoundland laws, has been incorporated into the draft *Act* in this Report.

The majority of the Commission recommends that:

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

2. **A proxy who acts in good faith according to the draft *Act* be protected from liability.**

10. There should be a duty to follow instructions unless there are compelling reasons for not doing so. A proxy should have the duty to act according to what he or she knows of the maker's wishes or, if unknown, according to the maker's best interests. A proxy should not be able to delegate authority.

In its *Discussion Paper* the Commission suggested that 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." One of the submissions received in response to the *Discussion Paper* suggested that the term "evidence of the person's intentions" was vague and that it would be preferable for proxies to follow instructions except where there is clear expression of a contrary wish or where there are changes in technology that would make the stated choice inappropriate in a way that is clearly contrary to the intention of the person.

The Commission, in its *Discussion Paper*, suggested that a proxy should not be allowed to delegate decision-making authority as was consistent with the view in other jurisdictions. None of the submissions suggested a contrary view and the Commission therefore holds with this recommendation which recognizes the maker's right to autonomy.

The majority of the Commission recommends that:

1. A person implementing an instructive directive have a duty to follow any relevant and unambiguous instructions in the maker's directive unless there are clear expressions of a contrary wish made subsequently by the maker while capable or unless technological changes make the choice inappropriate in a way that is clearly contrary to the maker's intentions.

2. A proxy have a duty to act according to what he or she believes the incapable person would want based on what he or she knows of the values and beliefs of the person and from oral instructions. If the proxy does not know the person's wishes, he or she make the health care decision that the proxy believes would be in the best interests of the person.

3. The proxy not be allowed to delegate decision-making authority to another person.

11. There should be limits on what a proxy can consent to on behalf of the maker.

In the *Discussion Paper* the Commission suggested that a proxy appointed by the maker of a directive should have the power to make personal decisions on behalf of the person and in essence, to act as a "guardian of the person". In light of submissions in response to the *Discussion Paper*, this position has been modified so that a person could only make personal care decisions of the type normally made by the guardian of the person if the maker specifically stated in the directive that this is what he or she wanted.

In keeping with the maker's right to autonomy, an advance health care directive may give the authority to a proxy to consent to any health care decisions the maker wishes. In its to *Discussion Paper* the Commission asked for input on the question of whether a proxy without specific instructions should be allowed to place the maker in a psychiatric facility. Among the submissions to the Commission some supported not allowing it[71] and others that it should be allowed.[72] A person chooses a proxy because the proxy is trusted to make appropriate decisions. Unless there are instructions to the contrary, the proxy should be able to consent to placement.

On the basis of these arguments the Commission decided that a proxy should have the authority to have someone admitted to a psychiatric facility unless the directive specifically directs that this is not authorized.[73] This position is consistent with the Newfoundland legislation. In Quebec, the situation differs. In Quebec law[74] it is possible to appoint a mandatary (proxy) to make decisions in the event of your incapacity. However, in the case of admission for psychiatric examination, it cannot be done without court approval if the person objects[75] as may be the case with someone who is mentally ill. This position has been criticized.[76]

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[71] *E.g.*, Ad Hoc Committee on Guardianship and Clubhouse Connections, Camp Hill Medical Centre.

[72] *E.g.*, Schizophrenia Society.

[73] Under the *Hospitals Act*, a person may be committed involuntarily if they fulfil the criteria of suffering from a psychiatric disorder, needing in-patient services, and being a danger to themselves or another person. A committal by a proxy would be considered a voluntary committal such that the criterion of dangerousness would not have to be fulfilled. Nonetheless, this would not guarantee that the person would have access to treatment since access would depend on the psychiatric assessment as to need and the availability of resources.

[74] *Quebec Civil Code*., S.Q. 1991, c.64 arts. 2166-74.

[75] *Quebec Civil Code,* S.Q. 1991, c.64, art.26.

[76] U. Greenbaum, "Right to Refuse Treatment Should Be Urgently Reconsidered", (January, 1995) *Share and Care: Newsletter of AMI Quebec.*

The majority of the Commission recommends that:

1. **A proxy be allowed, if authorized in an advance health care directive, to make any lawful decisions that the maker of a directive authorizes.**

2. **A proxy not be allowed to consent, unless expressly authorized, on behalf of the maker to procedures for the primary purpose of research; sterilization that is not medically necessary to protect the health of the maker; or the removal of tissue from the maker's body while living for transplantation to another person or for the purpose of medical education or medical research.**

12. In order to make health care decisions the proxy should have access to health care information which he or she would be allowed to use only for that purpose.

In its *Discussion Paper* the Commission suggested 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." One of the submissions received on this point suggested that what is "relevant" should not be left to health care providers. The wording in the draft law from the Alberta Law Reform Institute is consistent with this. It says that "a health care proxy has the right to be provided with all the health care information and records that the person for whom he acts as proxy would have if the person had the capacity to make a health care decision". This is in contrast to the Manitoba legislation and the recent Newfoundland legislation which allow all information "necessary to make informed health care decisions". This approach, as in the *Discussion Paper*, could leave it up to the health care provider to decide what was "necessary". The Commission has opted for the Alberta approach.

The majority of the Commission recommends that:

1. **Subject to any limitations set out in an advance health care directive, a proxy have access to all health care information that the person for whom he or she acts would have if capable of making health care decisions.**

2. **The proxy only use the health care information to carry out his or her duties.**

13. The law should contain procedural safeguards to contest a finding that the maker is incapable and to review misconduct on the part of a proxy.

The Newfoundland legislation imposes a duty on health care providers to record on the medical chart a finding of incapacity. The patient must be informed of the finding and of his or her right to contest the finding if it is confirmed by a second physician. In the draft *Act* in this Report an assessor as defined in the draft *Adult Guardianship Act*, rather than a physician, must provide the second opinion.

The suggestions in the Commission's *Discussion Paper* did not include a provision for court review of misconduct on the part of the proxy. The court has such authority in Nova Scotia's *Medical Consent Act* and it has been included in the draft *Act* in this *Final Report* for cases of misconduct.

The majority of the Commission recommends that:

1. **Health care providers have a duty to inform the person of a finding of incapacity and the fact that it can be contested if an assessor confirms this.**

2. **A person who contests a finding of his or her incapacity be presumed capable of instructing counsel and be allowed a hearing.**

3. **Any interested person who believes there has been misconduct on the part of a proxy be allowed a hearing.**

14. Health care providers should be protected from liability for complying with a directive or for not complying because they were unaware of its existence.

Family and friends of an individual who has made a directive may not always agree with the instructions provided by the person, particularly concerning the removal of life-support systems or the removal of artificial hydration and nutrition. It is important, therefore, that health care providers who follow a directive or the decision of a proxy not be subject to a law suit from family members or others who may disagree with the decision. As a result, most provinces with legislation include protection 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 suggested in the *Discussion Paper* 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 (treating against a person's wishes) and negligence (not treating when there is a duty to

treat). There were no disagreements with this proposition in the submissions received by the Commission and this position has been maintained in this *Final Report*.

The majority of the Commission recommends that:

Health care providers 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 and the law not contain sanctions against a health care provider who does not follow a directive other than those remedies available at common law.

15. The law on advance health care directives should recognize directives from out of province.

Submissions received by the Commission, in response to its *Discussion Paper*, emphasized the importance of recognizing directives from other jurisdictions whenever possible. One way of simplifying inter-provincial recognition is to find common areas of agreement in drafting legislation. This is not always possible since some provinces have more formal requirements than the Commission considers desirable or economically feasible.

The Newfoundland legislation does not contain a provision expressly recognizing a directive made in another province. The Manitoba legislation allows that a directive made outside Manitoba that complies with the Manitoba legislation will be considered one made in Manitoba. The 1992 provisions from the Uniform Law Conference of Canada[77] are more extensive and have been adopted in s.14 of the draft *Act* in this Report.

The majority of the Commission recommends that:

The law provide for recognition of advance health care directives from other provinces.

A number of submissions the Commission received in response to its *Discussion Paper* suggested that the draft legislation should allow makers to give instructions about issues relating to the maker's body after death. The Newfoundland legislation contains such a provision which allows those types of directions. In Nova Scotia, the issue of organ donation after death is addressed in the *Human Tissue Gift Act* where a signed donor card is the only document required to donate organs and bodily remains for transplantation or research. The Commission decided against including these issues in advance health care legislation on the grounds that they are addressed in our law already. Additionally, there are issues relating to health standards and the cost to the estate that could make some instructions impossible or impractical to comply with.

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

Finally, the Commission recognizes that individuals who wish to take all legal precautions to plan for their possible future incapacity will want to include an advance health care directive with an enduring power of attorney (relating to financial matters). The draft *Act* allows a combination of the two documents (an advance health care directive and an enduring power of attorney). The procedural requirements of the *Powers of Attorney Act* would still apply to the enduring power portion of the document.

IV SUMMARY OF RECOMMENDATIONS

ADULT GUARDIANSHIP

The Commission has a number of recommendations regarding adult guardianship. The primary recommendations of the Commission is adoption of the draft *Adult Guardianship Act* found at the end of this Report. Specifically the Commission recommends:

1. There be a Nova Scotia law which allows for the appointment of a guardian for an adult who needs one.

2. The law in Nova Scotia, as it relates to the court-ordered appointment of a guardian for an adult in need of one, be reformed.

3. The *Incompetent Persons Act* and the *Inebriates Guardianship Act* be repealed.

4. A law on adult guardianship reflect the following principles:

    * All adults have a right to autonomy and self-determination such that guardianship be used only as a last resort.

    * An adult who is the subject of a guardianship application be presumed to be capable of making decisions about his or her health care, personal care and well-being, and financial affairs until the contrary is clearly demonstrated.

    * The assessment of the capacity of an adult take into account the circumstances of the adult, the kinds of decisions the adult must make, the adult's way of communicating, and the available support and resources.

    * The court not appoint a guardian unless alternatives, such as providing support and help, have been tried or carefully considered.

    * A guardianship order be the least restrictive one possible.

    * The wishes of the adult in need of a guardian be taken into account in an order of guardianship.

5. A new Office of the Public Guardian be established in combination with the Office of the Public Trustee to provide advice and information on adult guardianship to the general public and to professionals, to screen applications, to monitor guardians, and to ensure that adults without a personal guardian receive the appropriate services.

6. The Public Guardian-Trustee in screening applications ensure that the adult is independently informed of the implications of the application and his or her right to representation.

7. The proposed guardian provide the court with a statement of intent as to how he or she will provide support and assistance to the adult in need of a guardian which will be used to measure the guardian's subsequent conduct.

8. Notice of an application to appoint a guardian be sent to a wide variety of individuals to ensure that the adult's interests are protected.

9. The person assessing the adult's needs allow a friend or representative of the adult, if available, to explain the purpose of the assessment and not conduct an assessment unless the adult consents.

10. An adult who is the subject of a guardianship application be presumed capable of instructing counsel.

11. The applicant be required to set out the reasons he or she believes the adult subject to the application lacks capacity and the extent of the alleged incapacity.

12. The assessor evaluate the present and projected needs of the adult and the ability of the adult to understand relevant information and to make and communicate decisions concerning specific tasks.

13. The assessment be multidisciplinary, comprehensive and, where possible, involve interviews with family, friends, and caregivers.

14. The applicant be required to set out in the application alternatives to guardianship that have been considered.

15. An assessment of the adult subject to the application be done before the court application unless the adult refuses consent or it has been established that one is unnecessary.

16. The court limit the authority of the guardian to include only what is necessary to assist the adult in need of a guardian.

17. The order be for a limited duration at which time the order will be reviewed.

18. Review of an order take place at least every three years and at any time on application.

19. The court assess the proposed guardian to ensure that he or she will act in the best interests of the adult.

20. The guardian have a duty to limit his or her interference into the life of the adult as much as possible and to encourage the adult to take part in decision-making as much as possible.

21. Any interested person who considers that a guardian is failing to carry out his or her responsibilities or is doing so improperly or in contravention of the terms of the order be able to file a complaint with the Public Guardian-Trustee.

22. The assessment ascertain whether the adult shows a preference for or a rejection of a particular guardian.

23. The attorney appointed under an enduring power of attorney and a proxy appointed in an advance health care directive be notified of a hearing so that they can reveal what they know of the adult's wishes.

24. The court inquire as to the wishes of the adult subject to the application and respect the adult's wishes to have an attorney or proxy act as guardian unless the court finds them unsuitable according to the criteria set out in the *Act*.

25. The court be satisfied before appointing a guardian that he or she will respect the wishes made by the adult when capable and will respect, as much as possible, the current wishes of the adult.

26. The guardian be required to follow clearly expressed wishes made by the adult while capable; act in the best interests of the adult if no earlier wishes are known; and consider current wishes of the adult that are in the adult's best interests.

B. ADVANCE HEALTH CARE DIRECTIVES

The majority of the Commission recommends that:

1. The law in Nova Scotia be reformed to permit a capable person who is sixteen years of age or older to make a wider range of advance health care directives and that the Government adopt the draft *Advance Health Care Directives Act* found at the end of this Report to replace the *Medical Consent Act*.

2. Advance health care directives be included in the law to:

    * allow a person to set out instructions or general principles about future health care decisions to be made on the makers behalf;

* appoint a proxy to follow instructions and interpret the general principles concerning health care decisions set out in a directive; or

* appoint a proxy to make health care decisions on the maker's her behalf.

3. A health care decision include consent, refusal or withdrawal of consent to health care including prevention, examination, diagnosis, treatment, and palliation of mental or physical disease, ailment, or disability.

4. A proxy can make personal decisions on behalf of the maker if specifically given authority in the directive.

5. An advance health care directive be effective whenever a person is unable to make health care decisions.

6. The law reflect the principle of autonomy and its purpose be to allow a capable individual a simple means of making health care decisions in the event that he or she is no longer capable of doing so.

7. There be no mandatory form for an advance health care directive but that the *Act* include a sample document to show people the types of issues they should be considering.

8. There be no formal requirement for registration or notification about the existence of an advance health care directive.

9. Although periodic renewal of an advance directive is desirable it not be mandatory.

10. If a person has not made an advance health care directive and does not have a guardian with authority to make health care decisions, there be a statutory list from which a substitute health care decision-maker can be appointed statutory proxy.

11. The maker of a health care directive be allowed to specify who is not to act as his or her statutory proxy.

12. No presumption arises from the fact that a person has not made an advance health care directive or has revoked one.

13. An advance health care directive be revokable if a person has capacity and that it 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.

14. A person 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. However, joint proxies should not be allowed and, where more than one is named in a directive, they should be presumed to act in succession

15. A capable person who has reached the age of nineteen years be presumed capable of acting as a proxy and there be no other restrictions on who can act as a proxy, such as ones based upon whether they will benefit from inheritance or an insurance policy from the maker.

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

17. A proxy who acts in good faith according to the draft *Act* be protected from liability.

18. A person implementing an instructive directive has a duty to follow any relevant and unambiguous instructions in the maker's directive unless there are clear expressions of a contrary wish made subsequently by the maker while capable or unless technological changes make the choice inappropriate in a way that is clearly contrary to the maker's intentions.

19. A proxy have a duty to act according to what he or she believes the incapable person would want based on what he or she knows of the values and beliefs of the person and from oral instructions. If the proxy does not know the person's wishes, he or she make the health care decision that the proxy believes would be in the best interests of the person.

20. The proxy not be allowed to delegate decision-making authority to another person.

21. A proxy be allowed, if authorized in an advance health care directive, to make any lawful decisions that the maker of a directive authorizes.

22. A proxy not be allowed to consent, unless expressly authorized, on behalf of the maker to procedures for the primary purpose of research; sterilization that is not medically necessary to protect the health of the maker; or the removal of tissue from the maker's body while living for transplantation to another person or for the purpose of medical education or medical research.

23. Subject to any limitations set out in an advance health care directive, a proxy has access to all health care information that the person for whom he or she acts would have if capable of making health care decisions.

24. The proxy only use the health care information to carry out his or her duties.

25. Health care providers have a duty to inform the person of a finding of incapacity and the fact that it can be contested if an assessor confirms this.

26. A person who contests a finding of his or her incapacity be presumed capable of instructing counsel and be allowed a hearing.

27. Any interested person who believes there has been misconduct on the part of a proxy be allowed a hearing.

28. Health care providers 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 and the law not contain sanctions against a health care provider who does not follow a directive other than those remedies available at common law.

29. The law provide for recognition of advance health care directives from other provinces.

Dissent of Commissioner Forgeron

I strongly urge the Government of Nova Scotia to reject the recommendations of the majority respecting advance health care directives (living wills). The adoption of such recommendations poses serious moral and ethical problems for our society. My dissenting opinion is based upon the following six concerns:

First, in Canada, health care decisions are based upon the legal doctrine of informed consent. Informed consent is the cornerstone of the law respecting health care. Informed consent has been defined as an agreement which a medical patient gives to a procedure after the risks involved are disclosed. [D.A. Dukelow & B. Nurse, *The Dictionary of Canadian Law* (Toronto: Carswell, 1991) at 513]. It is impossible to make an advance health care directive and at the same time base such directive on informed consent as the health care directive is premised on future contingencies. One is basically attempting to predict the future in terms of medical technology (which is constantly changing and advancing) in the absence of any specific knowledge of a future medical illness.

Second, advance health care directives are final once a person becomes incapacitated. The person is then not permitted to change her mind. People often do not recognize the precious value of human life until the moment that their life is to be taken away. Unfortunately, it is then too late.

Third, I am concerned that the draft *Advance Health Care Directives Act* moves beyond palliative care and potentially enters into the sphere of euthanasia. The recommendations are presented by using the example of the withdrawal of life support when a person is terminally ill. Discontinuing medical procedures which are extraordinary or refusing over-zealous medical treatment is not objectionable. Indeed such occurs legally and regularly in hospitals throughout Nova Scotia. A law respecting advance health care directives is not required to ensure the attainment of these legitimate objectives.

Fourth, the draft *Act* is not restricted to terminal situations. Advance health care directives take effect upon incapacitation. The proposed advance health care directives also permit the removal of hydration and nutrition (starving the patient to death). Thus, if a person were involved in a motor vehicle accident and was rendered unconscious, it is permissible to remove any artificial feeding, whether or not the person is terminally ill.

Fifth, the draft *Act* provides for statutory proxies. Thus even if a person has intentionally and consciously refused to make an advance health care directive because she wishes to exercise true informed consent in health care matters, this decision will be over ridden and a legislated proxy imposed.

Sixth, advance health care directives are potentially open to great abuse. The most vulnerable will continue to be the poor, the infirm, the aged, and the mentally and physically handicapped. As government resources decrease and as the aging population increases, the focus will shift from one where life is valued to one where life is measured in terms of cost effectiveness.

In summary, it is my position that an expanded range of advance health care directives is not necessary and is subject to many potential abuses. The Commission has adopted stricter measures of protection in its position on Adult Guardianship. In my view, these protective measures should be extended to matters of life and death and in fact, I would recommend that the existing *Medical Consent Act* be amended to include those protections. The greatest loss of liberty is the loss of life itself. We must ensure that life is valued and protected.