



<p style="text-align: center;"><b>Advance Care Plan</b></p>	<p>still has those same wishes and has not changed them. If the directive , whether in writing or oral or communicated by another means , does not contain wishes applicable to the decision the SDM now must make, then the SDM must decide what is in the best interests of the patient , using the directive as a guide. In an emergency, when it is not possible to talk with the patient or the SDM to get direction, physicians will refer to the advance directives, whether written or oral and act accordingly. The advance directive however expressed is not consent and physicians must still get consent before treatment from the patient or the SDM even if the patient has a written advance directive.</p> <p>Ref: A Guide to Advance Care Planning, ON (2006), Judith Wahl – Advocacy Centre for the Elderly</p> <ul style="list-style-type: none"> <li>• An advance care plan, no matter how specific, is an expression of a person’s wishes, values and beliefs, and these wishes, values and beliefs must be contextualized by a discussion with healthcare providers (about the disease, the prognosis, the treatment options, etc.), and they cannot replace informed consent regarding healthcare decisions, which must be sought by healthcare providers from a capable patient or the SDM if that patient is incapable. An advance care plan provides direction to a SDM, not the healthcare providers (with the exception of an emergency), in order to help the SDM feel confident in making future decisions if the patient becomes incapable. Completing an advance care plan is always voluntary and can take many valid forms in Ontario.</li> </ul> <p>Ref: Judith Wahl – Advocacy Centre for the Elderly</p>
<p><b>Substitute Decision-Maker (SDM)</b></p>	<ul style="list-style-type: none"> <li>• Someone who makes decisions on behalf of the patient if they become incapable of making them. The patient can choose to appoint anyone who is willing and able to act on their behalf and make decisions in the best interest of the patient to be their substitute decision-maker except: someone who is paid to provide personal care, someone who is mentally incapable or someone who is under 16. If the patient, while capable did not appoint a substitute decision-maker for personal care, the law provides a list of people who can act as the substitute decision-maker. The list below is in order of legal priority in Ontario:             <ol style="list-style-type: none"> <li>1. A guardian of the person with the authority to give or refuse consent to treatment</li> <li>2. An attorney for personal care with the authority to give or refuse consent to treatment</li> <li>3. A representative appointed by the Consent and Capacity Board</li> <li>4. A **spouse or partner</li> <li>5. A child or parent or Children’s Aid Society</li> <li>6. A parent who has only a right to access</li> <li>7. A brother or sister</li> <li>8. Any other relative (related by blood, marriage or adoption)</li> <li>9. The Public Guardian and Trustee is the decision maker of last resort if no other person is capable, available or willing to give or refuse consent</li> </ol> </li> </ul> <p>Ref: <i>Healthcare Consent Act</i> (1996), A Guide to Advance Care Planning, ON (2006)</p>

	<p>**Spouse/partner – either member of a cohabiting pair in relation to the other; one’s husband or wife, common law</p>
<p><b>Decision Making Capacity</b></p>	<ul style="list-style-type: none"> <li>• Decision-making capacity in Ontario requires that:             <ul style="list-style-type: none"> <li>➢ the patient be informed of his or her condition, prognosis, proposed treatments and alternatives; and</li> <li>➢ the patient understands the risks and potential benefits of each alternative and the consequences of choosing a particular alternative</li> </ul> </li> </ul> <p>A physician must determine that a patient is capable of giving consent and must obtain consent from a patient before providing treatment. A physician is entitled to assume that a patient is capable of giving consent unless there are reasonable grounds to believe otherwise.</p> <p>Ref: Royal College (2013), College of Physicians and Surgeons of Ontario (2013), <i>Health Care Consent Act</i> (1996)</p>
<p><b>Informed Consent</b></p>	<ul style="list-style-type: none"> <li>• A person has the right to consent or refuse treatment, admission to a healthcare facility or personal assistance services, if they have the mental capacity to do so. The person must have the capacity to understand and appreciate the consequences of a healthcare decision. Healthcare providers in Ontario cannot interpret and follow a patient’s advance directive or advance care plan directly. They must get informed consent from the patient or substitute decision maker if the patient is mentally incapable. Physicians may rely on advance directives/advance care plan as evidence of prior capable wishes in an emergency situation if no substitute decision-maker can be contacted in time.</li> </ul> <p>Ref: McMaster Health Forum (2013), <i>Health Care Consent Act</i> (1996)</p>
<p><b>Treatment Plan (Goals of Care/Care Plan)</b></p>	<ul style="list-style-type: none"> <li>• Allows a patient or substitute decision maker to consent or refuse to a range of treatment and personal care decisions in the context of a particular health care situation and its reasonably likely course. Elements of this decision-making encounter include:             <ul style="list-style-type: none"> <li>➢ Understanding of the illness including trajectory and prognosis, and potential outcomes of treatment options (including quality of life) from the perspectives of the patient, the family (including the SDM), and the healthcare team</li> <li>➢ Expression of the person’s values and what has meaning for him/her, and the goals of care identified in the current context of care</li> <li>➢ Fears the person may have, including concerns about the disease trajectory and, ultimately, the dying process</li> <li>➢ Disease and/or symptom thresholds which may inform when to change goals of care</li> <li>➢ Understanding how the person and/or their SDM prefer to make decisions (their desired role)</li> <li>➢ Recommendations by healthcare team members regarding the potential benefit and harm of life-sustaining treatments given the patient’s clinical situation and their values and wishes for care</li> <li>➢ Ensuring that medical decisions regarding care are clinically indicated, made and aligned with the patient’s goals for</li> </ul> </li> </ul>



<p><b>Do-not-resuscitate (DNR)</b></p> <p><b>Allow-Natural Death (AND)</b></p> <p><b>Comfort Measures</b></p> <p><b>Palliative Sedation</b></p>	<ul style="list-style-type: none"> <li>Refers to a written medical order that documents a patient’s decision regarding his/her desire to avoid cardiopulmonary resuscitation. DNR should not be mistaken as <i>do not treat</i>; it is specific only to CPR.</li> </ul> <p>Ref: It’s OK to Die (2013)</p> <ul style="list-style-type: none"> <li>It applies only when death is about to happen. Refers to decisions not to have any treatment or procedure that will delay the moment of death and comfort measures are taken.</li> </ul> <ul style="list-style-type: none"> <li>Any action taken to relieve pain or discomfort physically and psychosocially.</li> </ul> <p>Ref: It’s OK to Die (2013)</p> <ul style="list-style-type: none"> <li>Refers to the practice of relieving intolerable suffering through the intentional lowering of a patient’s level of consciousness in the last days of life by the proportional and monitored use of opioids/sedative medications. It is a very specific type of intervention only to be used when the patient cannot get relief any other way. Palliative sedation does not prolong or hasten death but addresses intolerable suffering. It is not the same as euthanasia.</li> </ul> <p>Ref: Canadian Hospice Palliative Care Association (2013)</p>
<p><b>Euthanasia</b></p>	<ul style="list-style-type: none"> <li>Knowingly and intentionally performing an act that is explicitly intended to end another person’s life and that includes the following elements: the subject has an intractable illness; the agent knows about the person’s condition; commits the act with the primary intention of ending the life of that person; and the act is undertaken with empathy and compassion and without personal gain.</li> </ul> <p>Ref: CMA (2007), NHS Choices (2012)</p>
<p><b>Physician Assisted Suicide</b></p>	<ul style="list-style-type: none"> <li>A physician knowingly and intentionally providing a person with the knowledge or means or both to commit suicide, including counselling about lethal doses of drugs, prescribing such lethal doses or supplying the drugs.</li> </ul> <p>Ref: CMA (2007), Comprehensive Cancer Centre – NorthWestern University (2013)</p>

<p><b>Pronouncement of Death</b></p> <p><b>Certification of Death (Medical Certificate of Death)</b></p>	<ul style="list-style-type: none"><li>• Is the determination that, based on a physical assessment, life has ceased. Allows the person to be moved to a local funeral home.</li><li>• A signed document provided to the government stating the cause of death. Certification of death can only be done by a physician or nurse practitioner. The death certificate must be completed within 48hrs of the death of an individual.</li></ul> <p>Ref: <i>Vital Statistic Act</i> (1990), CPSO Dialogue (2013)</p>
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