The Difference between “Care Planning” and “Advance Care Planning” - The Legal and Practice Perspective

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Introduction

The terms “care planning” and “advance care planning” are not defined terms in the law. However it is possible to explain these terms in context of the law as set out in the Health Care Consent Act and common law .This short paper is an explanation of the differences in these two practices from a legal perspective first in words and then in a chart to directly compare the two practices side by side.

People in the health system may confuse care planning and advance care planning This is clear when I have listened to programmes on the radio about the coronavirus and whether people should decide in advance whether they would want to be on a respirator so that those people won’t be taken to hospital if in long term care homes or won’t be offered a respirator as part of their treatment or other treatments and resources that might be in short supply.

A person or an incapable person’s substitute decision maker (SDM) can’t make that or any other firm “decision” in advance. This is a common misunderstanding about advance care planning that has appeared in a number of research initiatives and in forms and practices used in hospitals and long term care homes in particular.

Although some research studies may claim that a patient can make a decisions in advance of an illness before they have knowledge of the illness or may make decisions about what treatments they may want or not want if in certain states of health, this is NOT the law in Ontario.

From my legal research, this is also not the law in most other provinces. As the law in Quebec is a different legal system (Civil law as opposed to common law everywhere else in Canada) I do not know civil law well enough to come to conclusions about the state of the law in Quebec on this issue.

CARE PLANNING, which is a part of the Informed consent process, is often confused with advance care planning. With care planning, the patient of SDM is aware of the patient's illness and state of health and discusses with the health practitioners the possible trajectory of the illness. With care planning, decisions are being made about some future treatments with the same risks, benefits, alternatives and possible outcomes if treatment is refused. This is all in context of the patient's present condition and not if the patient develops a new illness or the illness takes a path not expected. In the law, there is reference to a **PLAN OF TREATMENT** which may be consented to. A "plan of treatment" means a plan that,

> "(a) is developed by one or more health practitioners,
>
> (b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and
>
> (c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition"

A plan of treatment cannot include health problems that the person may get that are distant from their present condition. It may include treatments for conditions that the person is LIKELY to have in context of their present condition. This is interpreted as conditions for which treatments have the same benefits , risks, alternatives (etc.) and are not new health problems, Informed consent – so all the information about any of the related health problems and the treatments included in the plan - must be obtained to anything that is included in the plan of treatment. This is also not advance care planning.

A simple example of this is resuscitation. That treatment may be an option for a patient but it may not be a recommended option in the opinion of the health practitioner based on their assessment of that patient. As this is in context of the patient's present condition, the patient or SDM may make a decision **– an informed consent** – about that treatment of resuscitation and refuse that treatment should their heart arrest. Although the treatment of resuscitation would be a "future" treatment that patient or SDM may give an informed consent to refuse or consent to that treatment. This is NOT advance care planning but is care planning which is an element of the Informed consent process.

Let’s go back to basics.

INFORMED CONSENT PROCESS

Before any decisions, called an **informed consent** in law is made by the patient or the patient’s SDM, until they or their SDM know what the patient’s illness is, and are given information from the health practitioner as to the severity or seriousness of the illness **(ILLNESS UNDERSTANDING**)

The health practitioner also must inform that patient or SDM of the possible and offered treatment options and know the risks, benefits, alternatives to the treatment options and what will happen if the treatments are refused. The Health practitioner must also answer any questions the patient or SDM may have about the illness or this information provided (**INFORMATION FOR AN INFORMED CONSENT**)

The illness understanding and the provision of this information is is the **CONSENT PROCESS.** Health practitioners must get an informed consent before treatment. Consent is not just the yes or no decision. That Yes or no decision (consent) is the final step in the consent process.

Many health practitioners also talk about getting patients **GOALS OF CARE** as if these are decisions (consents) about treatments. However that term “Goals of care” is not a legally defined term and is used in many different ways by physicians and other health practitioners. Some think it’s just the decisions or wishes about resuscitation or other end of life care like tube feeding,

Others think its equivalent to an informed consent to a treatment process that lets the physician the right to make treatment decisions for the patient in context of this more generalized goals of care discussion without getting specific consent.

Some health practitioners think that the “levels of Care “forms that list 4 or 5 general options such as full code, comfort care only, no transfer to hospital etc., often seen in long term care homes, are appropriate goals of care that direct the health practitioners what to do if the patient’s health has deteriorated and actions suggested in the general options should be considered. This is particularly problematic as most often patients or SDMs are told to complete the level of care forms with no discussion with a regulated health practitioner or no understanding of their illness or treatment options.

Goals of Care are NOT CONSENT to the physician to provide treatments without getting an informed consent. Level of care forms are NOT CONSENTS nor are they goals of care. A person cannot DECIDE in advance of an illness or health condition whether or not to just get comfort care or be transferred to a hospital. When there are goals of care discussions as part of the CONSENT process, the health practitioner cannot stop at the goals but must then get an informed consent to a treatment or plan of treatment. Goals of care will be put into context of the informed consent process in the chart.

I will include information about "offering" or not offering a treatment to a patient in the chart.

Informed consent may be provided by a capable patient or the incapable patients SDM for health care. .

CARE PLANNING

Care Planning is a step in the informed consent process and in particular is what is done when creating a Plan of Treatment. This was explained above in the Introduction so I won't repeat that here again. But it's important to understand that care planning does include talking with patients or their SDMs about future health problems that the patient is likely to have in context of their present conditions and the treatments and information about risks, benefits, alternatives etc. to these treatments before the plan of treatment is developed. That plan may include treatments that must be delivered by health practitioners other than the primary physician.

Care Planning may be done with the capable patient or the incapable patient's SDM.

ADVANCE CARE PLANNING

A common misunderstanding about advance care planning is that advance care planning results in decisions about future care and may be relied on by health practitioners directly instead of getting an informed consent before treatment or no treatment.

Advance care planning statements are NOT DECISIONS but are speculative WISHES often expressed out of any context or understanding of an illness or possible options, it's only when a person or their SDM has the information described above that a decision (called in law "consent" or "refusal of consent") may be given. It's unfair and not legal for health practitioners to rely on these wishes and not explain the illness and treatment options to the patient or patients SDM if the patient has advance wishes.

Just because a person says they don't want to be put on a ventilator before they get an illness and knows the direction that illness is taking to the best of the knowledge of the health practitioner and is given the information to give or refuse an informed consent to the treatment that is being offered, there is no decision and no consent to refuse that treatment.

Any such advance wishes are not directions to the health practitioner except in circumstances when there is an immediate emergency decision that must be made in regards to the life or death or risk of severe injury and the patient is unable to communicate or the patient's SDM is not immediately available to give or refuse consent, Otherwise the SDM is the person that relies on and applies the patient's wishes when making the health decisions for the incapable patient after the SDM has the information described above from the health practitioner . The SDM is entitled to all the same information as the patient when capable about the illness and the information for an informed consent.

Advance care planning Involves two steps.

The first step is a person, when capable, confirming or choosing by executing a power of attorney for personal care, who will be their SDM when they are not capable.

"Confirming the SDM" means that he patient is given knowledge of the Hierarchy list of SDMs in the Health Care Consent Act and identifies who is their future SDM for health care in that chart. The person in that patient's life that is highest in the chart is entitled to be their future SDM if that person is 16 years of age or older, mentally capable, not prohibited from being their SDM in documents such as a separation agreement or court order, and is AVAILABLE and WILLING to act as SDM and make the health decisions.

The second step is the patient when capable expressing their WISHES, not decisions, about future health care and explaining to the future SDM their values and beliefs which impact and affect how they make decisions about health care.

The wishes may be specific about treatments (whatever form they take) or may be general statements about what they think a quality of life is or isn't . The wishes need not be specific to health care. The wishes may be statements like "I do not fear living with a disability if the treatments necessary to keep me alive result in some physical limitations for me. "

Values and beliefs refer to religious beliefs that may impact on health decisions but also the moral and ethical \beliefs the person may have that influence their decision making,

Advance care planning may be done orally, or in writing, or communicated via whatever means the patient uses to communicate such as an assistive device. Even if wishes are written down on a chart or in some form of document like a power of attorney for personal care, the last known capable wishes expressed by the patient override the previous written or charted wishes.

WHEN AN SDM MAKES DECISIONS

The SDM when making decisions for the incapable patient must honour the patient's last known wishes however expressed IF APPLICABLE to the decision to be made. Many wishes won't be applicable in context of the patient's actual conditions and treatment options. If no such applicable wishes are known, then the SDM must make decisions for the incapable patient that are in the best interests of the patient.

Best interests is defined in the law as:

a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;

(b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and

(c) the following factors:

1. Whether the treatment is likely to,

   i. improve the incapable person's condition or well-being,

   ii. prevent the incapable person's condition or well-being from deteriorating, or

   iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.

2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.

3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.

4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed. 1996, c. 2, Sched. A, s. 21 (2).

The SDM also has some leeway in not honouring a wish in two circumstances”

- If the SDM believes that patient would have changed their wish to refuse a treatment if the patient knew what their present health condition would be and treatment options, the SDM may apply to the Consent and Capacity Board for an order to not follow that wish.
- If the SDM believes that a wish is impossible to follow, then the SDM does not need to follow it

Advance Care planning may only be done by a CAPABLE PERSON. SDMs cannot advance care plan for an incapable patient. They can only give or refuse consent, they can do care planning for the incapable patient.