The law and practice associated with advance directives in Canada and Australia: Similarities, differences and debates

Margaret Brown*

This article is a summary of research that investigated the Canadian and Australian legislative framework associated with advance directives in health care. The research focused on the context in which older people are encouraged to use advance directives. These are directions about refusal of medical treatment given in advance of incompetence. An advance directive may be given in a written document (living will) expressing one’s wishes, by appointing another person (proxy) to make the decisions, or as a combination of the two. A lack of consistency and clarity about the terminology was found in both countries. This could be a barrier for older people to express their wishes in advance. Several confusing issues were also identified with the legislation related to advance directives. There appears to be a move towards appointing a substitute decision-maker, but with significant differences across the Australian States and in Canadian Provinces. The “conversation” about future decisions emerged as an important theme, together with an emphasis on the process of “advance care planning” replacing the focus on advance directive forms.

INTRODUCTION

This article is a summary of research that investigated the Canadian legislative framework associated with advance directives in health care, and the ways in which advance directives are used in Canada and Australia. The research focused on the context in which older people are encouraged to use advance directives and how they are informed about making decisions in advance of future possible incompetence. These decisions are usually about care at the end of life.

This article is not a discussion about the types of medical decisions involved (including issues of determining competence) and the way advance directives might be interpreted at the end of life. Nor is it an analysis of the legislation and the differences in the laws between the Canadian Provinces and the Australian States. That is a very complex task, which is beyond the scope of this work.

This investigation’s primary purpose was to identify relevant legislation and educational material, and to consult with researchers about how older people gain access to information about their rights on issues of consent in both Canada and Australia. The law and practice in end-of-life decision-making are rapidly developing and changing in both countries, and hence a dialogue between the two is important.

The subject is complex and multi-faceted, crossing the boundaries of law and medicine, and going beyond disciplines to encompass values. It is essentially about dying and death. It challenges people to think about their non-existence. This could be considered one of the ultimate challenges in our

* BA, MPH, MSc, Research Fellow, Hawke Institute, University of South Australia. This research was made possible by a grant from the Canadian Studies Program Faculty Research Award in 2001. The author thanks all the key informants who were interviewed. Their open responses and enthusiasm for the philosophy which advance directives represent provided a rich background for this discussion. The author also thanks Kate Leeson and Susie Brown for editorial assistance and Margaret Bowden for her assistance in preparing this article.

Correspondence to: Margaret Brown, Research Fellow, Hawke Institute, University of South Australia, Magill, SA 5072, Australia; email Margaret.Brown@unisa.edu.au.

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modern Western society, which does not deal well with death. The term “advance directive” can be seen as a metaphor for death – a metaphor that provides a language to enable people, including health professionals, to discuss some of the issues about death. The findings in this article suggest that the metaphor is changing and no longer relates only to the refusal of medical treatment in advance of incompetence. It now encompasses the decisions individuals may wish to make about their life as it draws to an end, when they are no longer able to communicate how and where they wish to live and die, and how they should be treated. This research demonstrates that the law is moving in that direction in both Canada and Australia, with the rate of change in Australia slower than in Canada.

The task of unravelling the layers of this subject’s complexity will continue in further publications; hence, this discussion can be seen as the beginning of that dialogue. This article should be considered as a work in progress – an attempt to open up a discussion between these two similar but different societies.

GIVING DIRECTIONS IN ADVANCE: WHAT DOES IT MEAN?

There is a substantial body of published literature about advance directives, much of which assumes a common understanding of the term. It can be found primarily in medical and ethics/bioethics literature and journals, and to a lesser extent in legal and social science publications. This literature comes from the United States of America, Canada and a few articles from Australia. It has identified many of the barriers to executing an advance directive and problems with interpreting forms. However, there is little discussion about the concept – the philosophy that underpins the term “advance directives” – and the way in which this is changing in Canada and Australia. The lack of consistency in the terminology is rarely discussed, even though this confusion can be a barrier. It was this confusion that became an ongoing theme throughout this exploratory study.

For the purpose of this discussion, an advance directive will be defined as a document which gives directions about medical treatment in advance. It can be described as an instrument for making decisions while one is still competent and before a serious illness occurs. An advance directive is either in the form of a written document, which expresses one’s wishes in writing (also called a “living will” or “instructional directive”), or it involves appointing another person to make the decisions (proxy or medical power of attorney) if an individual is no longer able to do so. It may also be a combination of the two.

An advance directive embodies the principle of autonomy – the right of self-determination. It aims to promote empowerment, compassion and dignity at the end of life. Advance directives are based on the premise that, if people know that their autonomy will be respected and they can have some say about their treatment decisions when they are dying, they will be able to confront their death with less anxiety. They will know that burdensome and futile medical treatment will be avoided if they become incompetent during the dying process or if an irreversible condition leaves them with severe brain damage.

RELEVANCE FOR OLDER PEOPLE

“Advance directives” are particularly relevant for the increasing number of older people who may be able to confront their death with less anxiety if they feel assured that technological intervention will not protract the dying process unnecessarily. Knowing that their autonomy will be respected and that, if possible, they will be involved in decisions surrounding their death, should reduce the fear and
stress associated with dying. It is not death which people fear most but dying. The rationale for this argument comes from a large body of literature that demonstrates that human beings cope better with stress when they feel they have control.\(^3\)

A substantial number of people aged 65 and over in Australia and Canada die in hospital where the more rigorous medical treatments are most likely to occur and hence the right to refuse treatment becomes more critical. Therefore, executing an advance directive to make future decisions about health care is most appropriate for this cohort of people. However, research identifies many barriers that inhibit older people from executing an advance directive, such as not wanting to place a burden on the person they choose to appoint as an agent and the difficulties in actually expressing their wishes in writing. Some older people prefer to leave the decision to the doctor. This tends to increase with the person’s age.\(^4\) Few studies have looked at barriers for older people from non-English-speaking backgrounds. These barriers extend beyond language and access to information, and raise significant cultural issues that are yet to be addressed.\(^5\)

**TO LEGISLATE OR NOT TO LEGISLATE: BALANCING RIGHTS WITH PROTECTION**

Many countries have introduced advance directive legislation in recent years, starting with the United States of America. The concept of advance directives arose there as a response to rapid developments in life-extending medicine, which prompted some authors to argue that the doctor’s goal appeared to be patient survival rather than allowing patients to die. Callahan refers to this phenomenon as “the forestalling of death”.\(^6\) Veatch, an American ethicist, states that “death, as never before, is looked upon as evil, and we are mobilizing technology in an all-out war against it. If not death itself, at least certain types of deaths are beginning to be seen as conquerable.”\(^7\)

At the same time, individualism and individual rights began to emerge as a dominant force in America, Canada and Australia. This was reflected in health care in the patient rights movement in Australia\(^8\) and the “right to die” movement in the United States. In the 1960s and 1970s people became increasingly concerned about the number of incurably impaired people, particularly the aged, who were kept alive for prolonged periods with medical technology. Many of these people may well have refused treatment if they had been competent or if there had been a legal framework for either themselves or their relatives to claim their (common law) right to refuse treatment.

The first “living wills” were letters that individuals wrote to their families and loved ones stating that they would not want to have their life extended artificially if they were no longer competent to make the decisions for themselves. Living wills are now recognised as informal advance directives. The first *Natural Death Act* was passed in California in 1976 following the famous and influential case of *Re Quinlan* 335 A 2d 647 (1976).\(^9\)

Australia followed suit when its first living will legislation, the *Natural Death Act 1983* (SA), was enacted in South Australia. Similar legislation in the Northern Territory followed in 1988 (the *Natural Death Act 1988* (NT)). The intention of these Acts was to establish support for an individual’s right to “die with dignity”, and to provide individuals with the right to refuse “extra-ordinary measures” if they were in the terminal phase of a terminal illness and unable to make decisions at the time.\(^10\) The concept of planning ahead and documenting one’s wishes in a living will, together with appointing a

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\(^3\) See below at 71 for discussion about Bowman’s research.


\(^7\) Karen Ann Quinlan was a young woman in a coma for 10 years before the court’s established the right of an incompetent patient to forgo life-sustaining treatment and the right of the patient’s guardian, family and physician to make the decisions on behalf of the patient.

\(^10\) Brown, n 1, Ch 3.
medical power of attorney (durable power of attorney, a proxy or agent) to make those decisions, was not introduced within the medical paradigm until *Cruzan v Director, Missouri Department of Health* 497 US 261; 111 L Ed 2d 224 (1990). In 1991 the United States Congress passed the *Patient Self-Determination Act*. This requires all hospitals, nursing homes and health care agencies to advise patients of their rights to accept or refuse medical treatment, and to execute an advance directive. Each State now has advance directive legislation, and the law and language in the United States has influenced policy-makers in Canada and, to a lesser degree, Australia. Britain, on the other hand, has not proceeded with specific advance directive legislation, although comments made in *Airedale NHS Trust v Bland* [1993] AC 789 indicate that advance directives are binding in common law.

ADVANCE DIRECTIVES IN AUSTRALIA

The current legal position in all Australian and Canadian jurisdictions is that competent adult patients have a common law right to consent to, or refuse, medical treatment, including life-sustaining treatment. It is now clear in both the law and health care ethics that competent patients have the right not to be treated without consent and a corollary right to be provided with adequate information to make informed decisions about their medical treatment. However, this does not address the problem of incompetence, when people are no longer able to make decisions for themselves when they become very ill, especially at the end of life.

As mentioned, Australia’s first living will legislation was the *Natural Death Act 1983* (SA), followed by the *Natural Death Act 1988* (NT). In Victoria, the *Medical Treatment Act 1988* (Vic) was passed in 1988, and amended in 1990 to include an enduring power of attorney for medical treatment should the person be incapable. In 1992 the *Medical Treatment (Agents) Act 1992* (Vic) was passed to allow the appointment of alternate agents. The Victorian legislation is limited in its application, as it only applies to current medical treatments that would cause “unreasonable distress to the patient”.

In South Australia, the Parliamentary Select Committee found that the *Natural Death Act 1983* (SA) was limited in its application, relatively unknown and not used. It was repealed and replaced with the *Consent to Medical Treatment and Palliative Care Act 1995* (SA). The Schedules to this Act allow the appointment of a medical power of attorney (Sch 1), and written decisions given in advance about medical treatments in an “Anticipatory Direction” (Sch 2).

An extensive public and professional education campaign was carried out in South Australia after the introduction of this Act to inform the public and health professionals about it. This campaign included distribution of brochures to help the public and health professionals understand its implementation, but it provided little guidance about what types of decisions might be made, and under what conditions, to assist doctors and/or relatives to carry out the person’s wishes.

When this Act was introduced, it was assumed that doctors would be involved in advising patients about completing the Schedules because they are about consenting to, or refusing, medical treatment. This has not been the case, however, and many doctors are not aware of the Schedules, even though they have to be familiar with the law of informed consent. The Schedules have not been widely used in South Australia, even though some lawyers inform their clients about the Schedules and the enduring power of guardianship (discussed below) when they discuss enduring power of attorney with them.

The results of an earlier study with older people in South Australia indicated that some participants would want to discuss their treatment choices with a doctor and others would not. Several thought

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11 Nancy Cruzan, another young woman in a persistent vegetative state, was kept alive with artificial feeding. The court confirmed the principle that a competent person has the right to refuse unwanted medical treatment, including artificial feeding.


15 Interview with South Australian Public Advocate and practising lawyer (2001).
they would prefer to consult with a lawyer, as the Schedules are legal documents.\textsuperscript{16} However, this raises questions about financial costs and accessibility, especially for older people on pensions and others with limited resources.

More recently, Queensland has moved in a somewhat different direction and combined the advance health directive with the enduring power of attorney for financial affairs under the \textit{Powers of Attorney Act 1998} (Qld). Research in Queensland also revealed that older people wanted the right to express their wishes either in writing or by appointing a proxy, and many wanted to discuss their preferences with a doctor.\textsuperscript{17} The \textit{Prepare-Your-Own Enduring Power of Attorney and Advance Health Directive} pack states that one can either “prepare your own” or use a lawyer.\textsuperscript{18} It includes forms to record one’s wishes about refusal of treatment in advance, which can be used separately or in conjunction with appointing an attorney for personal and health care matters. However, people will still need to see a doctor, as the Act requires that a person sign the health directive in the presence of a doctor.\textsuperscript{19}

Australia does not have uniform advance directive legislation throughout the different States and Territories. Five of the eight States and Territories have “advance directives” legislation or the right to refuse treatment in a written document, whereas only four States have legislation allowing the appointment of an agent or proxy for health care decision-making.\textsuperscript{20} However, there is a move in Australia towards including the concept of an advance directive within the enduring powers of guardianship under guardianship and administration legislation developed for the protection of persons with mental illness. An enduring power of guardianship instrument can be used to appoint a proxy/attorney/agent to make decisions that include lifestyle choices, as well as health care decisions. The \textit{Guardianship and Administration Act 1993} (SA), for example, enables people to appoint an enduring guardian to make decisions for them should they become incompetent in the future. Under this Act, these decisions include “personal decisions, such as choice of accommodation, relationships with others, holidays and all medical treatment decisions should mental competence be lost in the future”.\textsuperscript{21}

The South Australian Public Advocate uses the term “advance directive” to include any written statement that expresses a person’s wishes or directions in advance, should mental capacity (competence) be lost in the future. This definition of an advance directive includes a will – which only applies once the person who makes it dies – and

- an enduring power of attorney (EPA) (under the \textit{Powers of Attorney and Agency Act 1984} (SA));
- an enduring power of guardianship (EPG) (under the \textit{Guardianship and Administration Act 1993} (SA));
- a medical power of attorney (MPA); and
- an anticipatory direction (AD) (under the \textit{Consent to Medical Treatment and Palliative Care Act 1995} (SA)).\textsuperscript{22}

This is an example of the term “advance directive” being broadened to encompass all decisions related to a person’s life, not just medical decisions. It is unusual to include a will within the meaning of an advance directive. A similar move has occurred within the Queensland legislation, but advance health directives are governed by the \textit{Powers of Attorney Act 1998} (Qld). This broadening of the

\textsuperscript{16} Brown, n 1; Brown M, Wakefield M, Beilby J and Gargett E, \textit{Advance Directive (Schedule 2) Community Study: Final Report} (University of South Australia, Adelaide, 1997).


\textsuperscript{18} \textit{The Prepare-Your-Own Enduring Power of Attorney and Advance Health Directive} (Nation Wise Products, Virginia, Queensland, 2000).

\textsuperscript{19} \textit{The Prepare-Your-Own Enduring Power of Attorney and Advance Health Directive} (Nation Wise Products, Virginia, Queensland, 2000).


\textsuperscript{21} Harley J (ed), \textit{An Information Resource for Service Providers in the Aged Care Sector} (Office of the Public Advocate, Collinswood, South Australia, 2000) p 3.

\textsuperscript{22} Harley, n 21.
concept to include a more holistic approach to end-of-life decisions requires further discussion and analysis beyond the scope of this article.

Currently all States in Australia have guardianship legislation, but in Western Australia and the Northern Territory this legislation does not include an instrument for an enduring power of guardianship. This means that Western Australia does not provide a legal mechanism for making advance directives for either medical decisions or the broader issues discussed above.

The information in this section demonstrates the inconsistencies within the Australian context in legislation, interpretation and accessibility for the public, especially the older public who may well wish to proceed with some form of recording their wishes or appointing a proxy to make decisions for them when they are no longer able. It is not clear that directives executed in one State would be accepted as legal documents in another. As yet there is no research in this country on how lawyers advise their clients about expressing their wishes for future medical treatments. A small study with general practitioners in South Australia suggests that, for the few doctors who are informed about the law in that State, advising patients about future decisions takes time that is often not available in a busy general practice. Dealing with the types of decisions required is difficult and the uncertainty about the legal documents (including the enduring power of attorney and medical power of attorney) is confusing.

ADVANCE DIRECTIVES IN CANADA

The Canadian approach to advance directives is more like the Australian approach than that of the United States, but this research indicates that advance directives, couched in various terms, attract a much higher profile in Canada than in Australia. There is one obvious reason for this – proximity to the United States. As one key informant said:

[T]here is this huge influence from the States. So all the stuff that people think about living wills and advance directives is American based so they [legislators] decided purposefully not to use that terminology, to try to stay away from that although it has crept right back in there because everyone uses it ... the influence of the States is just overwhelming.

End-of-life care is also influenced by the more aggressive treatments used when people are dying in the United States. Several informants referred to the concern that people (especially seniors) have about the potential for being kept alive when they are no longer competent to refuse treatments such as feeding tubes and life support.

Informants also acknowledged their concern about the continuing death-denying attitudes amongst health professionals and the community in Canada.

The Canadian Provinces did not pass natural death legislation in the 1980s, although there has been considerable emphasis on “living wills”, which can be recognised under common law and current provincial legislation. There is no federal law similar to the Patient Self-Determination Act in the United States, but there are laws in each Province (but not the Territories) that are described as advance directive legislation for the purpose of this discussion.

The term “living will” is currently used in Canada but with no clear definition. Both “living will” and “advance directive” (and other similar terms) appear in literature and policy documents, together with a considerable emphasis on substitute decision-making.

There are clear statements in national policy documents promoting the use of advance directives. In 1995 the Canadian Senate released a report on end-of-life care. This recommended that those Provinces and Territories that did not have advance directive legislation should proceed to legislate, and all Provinces and Territories should establish a protocol to recognise advance directives executed

25 “Seniors” is the term used in Canada to denote older people.
27 Ashby M, Of Life and Death: Report of the Special Senate Committee on Euthanasia and Assisted Suicide (Senate of Canada, Ottawa, 1995).
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in other Provinces. In June 2000 the Senate released an update of this report called Quality End-of-Life Care: The Right of Every Canadian, which states:

Witnesses stressed that advance directives, whether instruction directives (telling the physicians what types of treatment the patient does or does not want) or proxy directives (designating a certain person to make the patient’s medical decisions), should not be viewed as purely legal documents. Whether people give too little or too much detail in their advance directives, there may be interpretation problems, with physicians and family members sometimes disagreeing on the meaning. Most people do not update their advance directives, and family members may feel that a dated advance directive does not reflect the patient’s current thinking. Sometimes medical staff may not be aware that an advance directive exists, although witnesses recommend the use of a wallet-sized card or bracelet to signal the existence of an advance directive. 28

This report refers to the “traditional” view of advance directives, even though the concept of advance directives has only emerged in the last three to four decades. The committee stated that most of the problems cited above arise from the “traditional” view and that advance directives should be seen as part of an overall

planning and communication process that helps people prepare for death in the context of their loved ones. The preparation of an advance directive can facilitate discussions between people and their family, and provide guidance and support for substitute decisions-makers who must make the difficult decisions regarding life-sustaining treatment. If loved ones and medical professionals have engaged in a process of serious communication, the problems associated with the interpretation and application of advance directives are much less likely to arise. The passage to death is eased, the level of comfort rises, and the burden of care is lightened for the substitute decisions-maker. 29

Research centres

Two research centres based in Ontario have published widely on end-of-life decision-making. They are the Joint Centre for Bioethics (JCB), University of Toronto, and the Geriatric Research Group at Hamilton Hospital, Ontario, in conjunction with McMaster University.

Joint Centre for Bioethics

The Joint Centre for Bioethics, University of Toronto has developed a website (www.utoronto.ca/jcb/lwdisclaimer/jcblw.htm) containing information on “living wills” in Canada. 30 Dr Peter Singer and members of the Centre have been researching end-of-life decision-making and advance directives for almost a decade. The information on the website is presented in three languages – English, French and Italian – and can be downloaded. It is also available in hard copy (English version only) together with a video from the Centre. The booklet defines terms used, information about the legal status of living wills in Canada and forms which individuals can complete to record their decisions in advance. Instruction directive and proxy directive forms are included on both the website and in the booklet. The term “living will” is inclusive of both forms and should, if possible, contain both of these directives. The Centre has also developed disease-specific living wills for cancer and HIV, which are included in the booklet in French, Italian and English.

The website document includes the disclaimer that:

It is not legal advice and is not a substitute for the advice of a qualified practitioner in your home jurisdiction.

…The members of the Joint Centre assume no liability or responsibility for any errors or omissions in this website content. 31

30 University of Toronto Joint Centre for Bioethics, Living Will (University of Toronto Joint Centre for Bioethics, Toronto, 21 June 2001, revised ed); see www.utoronto.ca/jcb. The information was originally posted on the website on 31 May 1999; revised 26 June 2001.
31 See www.utoronto.ca/jcb/lwdisclaimer/jcblw.htm, p 1.
One is required to agree to the terms of the disclaimer before obtaining access to the site. It is stressed that a living will is a legal document “with serious legal implications” and readers are advised that if they intend to use the living will document provided, they should review it with both their doctor and a lawyer who is experienced in living wills. This section is in a question-answer format to guide readers and make them think seriously about what they are doing.

Definitions of terms such as “proxy directive”, “instruction directive” and “advance care planning” are provided:

A living will, sometimes called an “advance directive”, is a document containing your wishes about your future health or personal care. You make a living will when you are able to understand treatment choices and appreciate their consequences (that is, when you are “capable”). A living will only takes effect when you can no longer understand and appreciate treatment choice (that is when you are “incapable”).

Living wills that meet certain technical requirements are also called “health care directives”, “advance health care directives”, “representation agreements”, “mandates”, “authorisations”, “personal directives” and “powers of attorney for personal care”, depending on the Province in which one lives. The fact that all of the above material on living wills (on the website and in booklet form) is only available in English, French and Italian raises the question of accessibility, as Canada (particularly Toronto), like Australia, has many different nationalities and language groups. There is also the question of confusion created by the use of so many different terms, the lack of consistency across the country, and how accessible the information is for older people, many of whom are not computer literate or simply do not have access to the necessary technology.

Geriatric Research Group

Research on living wills/advance directives has also been carried out by researchers from the Geriatric Research Group at Hamilton Hospital, Ontario, led by Dr William Malloy of McMaster University. In 1989 Malloy and Mepham published a small booklet titled Let Me Decide: The Health Care Directive that Speaks for You When You Can’t. This publication has been adapted for the Australian context and in 2000 it was revised and expanded for the United States. This new version claims to be “the world’s most widely used living will: more than 1 million copies sold: available in 7 languages.

It clearly states its purpose in the introduction, and contains a tear-out directive with space for a personal statement and a health care chart: “The purpose of the booklet is to help you take control of – and help to record your wishes for – your health and personal care, if you were unable to speak for yourself.”

This booklet is used in some aged care facilities to assist with decision-making for older people on admission to the facility in Canada and Australia.

Other information on living wills/advance directives

Another option is to buy the package Last Will and Testament and Living Will from bookstores and government printing offices. This includes a form and disk, “professionally designed and ready to use”. Under the heading “Living Will” it states: “This form allows you to express your wishes regarding life support system and health care.”

Different groups across Canada have developed information packages specifically for seniors. My Plans for Me: Educational and Information Package on Advance Health Care Directives in Canada is available in four parts. The Canadian Pensioners Concerned Inc and Health Canada funded this package, and the Pensioners Concerned Association promotes it widely to seniors.

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32 See www.utoronto.ca/jcb/ jcblwdisclaimer/jcblw.htm, p 1.
35 Molloy, n 34, p 3.
37 Canadian Pensioners Concerned Inc, My Plans for Me: Educational and Information Package on Advance Health Care Directives in Canada (Canadian Pensioners Concerned Inc and Health Canada, Ontario, 4 part series, 1997).
Many other groups involving seniors throughout the country are promoting the idea of taking control of one’s decision-making in advance of incompetence. However, there seems to be a lack of clarity about how one should proceed and from whom one should seek advice in executing an advance directive. In a discussion about advance directives with a group of businessmen and their partners, the author found that they thought the best way of seeking advice on executing a living will and appointing an attorney would be to consult a lawyer, financial adviser and/or accountant. No-one suggested discussing the decisions with their doctor, and none had heard of the term “advance directive”.  

There was no consistency in the Canadian material surveyed about whether individuals should seek advice from a doctor or a lawyer. Some recommended doctors, some recommended lawyers and some recommended both. One key informant stated clearly: “These are legal documents that have legal force and effect … I would know very few doctors who would ever want to help you make a document like that.”

A Guide to End-of-Life Care for Seniors was released in 2000. This guide is distributed widely and is also available on CD. Information about obtaining the CD is available on the internet. Once again, access to this type of information assumes that seniors are computer-literate, and know where and how to search.

The advance directive information in this guide is within the chapter on ethical issues. This includes informed consent, substitute decision-making, capacity and advance directives within the context of advance care planning. The guide states:

- Advance directives are now recognized as legal, or at least deserving of consideration, in nearly all provinces. Seniors who may be reluctant to use advance directives may prefer that their families make decisions for them and they are likely to discuss their treatment preferences with them. It may be that the most important aspect of advance planning for end-of-life situations is the conversations about these issues between individuals and their families, including those who will be expected to make surrogate decisions. However, putting all decisions into writing is always best.

This section continues with the statement:

- Many health care facilities have had difficulty with advance directives in that some seniors refuse to complete them. Some facilities use a “level of intervention” document to deal with advance care planning.

This illustrates the confusion, as this is yet another set of forms that are often referred to as “advance directives” or “level of care” forms. Several commentators expressed concern about these “level of care” forms. Some aged care facilities develop their own forms while others use already established ones such as the Let Me Decide booklet. Some aged care facilities insist that these forms are completed on admission to the facility in order to gain information about the level of care residents would or would not want once they are unable to make decisions. The intention of having the forms completed prior to admission is to enable the facility to treat the individual as he or she would want, and to provide a guide in an emergency situation or if the person is dying. However, the informants expressed concern that these “level of care” forms were taking the place of consent from either the resident or their proxy. In other words, these forms are tending to replace the legally recognised process under the current legislation. As one informant said: “They are not legally enforceable.” Another said: “Staff in facilities are totally consumed by the forms and the decisions made on admission – these are not usually expressed by the individual themselves.”

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38 The author was invited to present her research on advance directives to a group of businessmen and their partners (28 in all) in Toronto, August 2001.
41 See www.hc-sc.gc.ca/seniors-aliments.
42 Fisher, Ross and MacLean, n 40, p 87.
43 Fisher, Ross and MacLean, n 40, p 87.
These comments and the author’s research results so far indicate that a lot more work needs to be done on clarification, accessibility and implementation of advance directives if they are to serve their intended purpose.

The next part of this discussion will focus on the findings from two Provinces: Ontario and British Columbia. It will briefly summarise findings from materials collected whilst in Canada and interviews with key informants in both Provinces, with a particular emphasis on Ontario.

**Legislation in Ontario**

The advance directive legislation in Ontario is encompassed within two Acts: the *Substitute Decisions Act 1992 (Ont)* and the *Health Care Consent Act 1996 (Ont)*. These Acts were proclaimed in 1996, together with the *Advocacy Act 1992 (Ont)*, which has since been repealed. The booklet associated with the current Ontario legislation contains forms for a continuing power of attorney for property and a separate form for the power of attorney for personal care under the *Substitute Decisions Act 1992 (Ont)* (amended and proclaimed in 1996). This booklet is freely available from the Public Guardian and Trustee Office, lawyers and financial advisers on request.

The signatures have to be witnessed for the powers of attorney for both property and personal care. It is recommended that individuals seek advice from a lawyer and health care provider for the power of attorney for personal care.

Powers of attorney for personal care are documents in which an individual can name a substitute decision-maker (an attorney), as well as setting out wishes about care. If an individual wants to change her or his wishes, he or she can either rewrite the new wishes or express them orally without changing the written document. This “oral override” means that the substitute decision-maker can make decisions about refusing medical treatment, as long as he or she has discussed the decisions prior to the grantor’s incompetence.

Hence health care wishes can be expressed verbally, or informally in a letter. There is no actual need to complete a living will/advance directive, although it is recommended in some of the printed material for seniors.

The *Health Care Consent Act 1996 (Ont)* provides a ranking (or hierarchy) of people who can make decisions on behalf of individuals in an emergency or when they are no longer able to make those decisions themselves. This means it is not necessary to have a legally appointed substitute decision-maker for health care decisions. The legislators chose this approach to cater for the many people (the majority) who do not appoint a surrogate decision-maker legally, particularly people from other cultures. As one informant pointed out: “Some people will never sign documents for all kind of reasons. These are hugely powerful documents.”

This informant then spoke of the abuse associated with delegating decision-making powers to others.

As a researcher (and not a lawyer) it was not an easy task for the author to clarify these points and understand the complexity of the law and the implications of completing these documents. It raised significant questions about how older people can access information. There is an expectation that people will consult a lawyer for clarification and guidance. Once again this begs the question of expense, especially for older seniors on limited incomes. The ongoing question of accessibility of information for the thousands of people from other cultures and other languages does not appear to be addressed adequately.

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45 The process changed after the *Advocacy Act* was repealed in 1996 and several informants spoke of the publicity that surrounded the debates at the time and the legacy of confusion that followed, even amongst health professionals. The history of this legislation illustrates the impact the political process has on the way legislation is formulated.

46 The author telephoned the Public Guardian and Trustee Office to obtain the booklet and seek advice about how one would proceed with executing powers of attorney but could only access information using the telephone menu and leave her name and address for copies to be sent. Two informants confirmed similar experiences and stated that one could wait several hours if seeking assistance other than urgent guardianship orders.

47 Personal care has six components: health care, nutrition, safety, hygiene, clothing and shelter.

48 Interview, Toronto 2001. The *Health Care Consent Act 1996 (Ont)*, cl 2, Sch A, s 5(3) states: “Later wishes expressed while capable prevail over earlier wishes.”

49 *Health Care Consent Act 1996 (Ont)*, cl 2, Sch A, s 20(1). This lists eight categories including guardians, attorneys for personal care, representative appointed by the Board, spouse or partner, child or parent, brother or sister and relative.

The law and practice associated with advance directives in Canada and Australia

The ACE (Advocacy Centre for the Elderly) Newsletter, in clarifying the current legal situation for seniors, states:\(^{51}\)

[A] living will/advance directive does not name a substitute decision-maker. It ordinarily is only a statement of your wishes, values and beliefs. These wishes are a guide to the person who would be your substitute decision-maker for health from the list of decision-makers in the Health Care Consent Act. As neither the Substitute Decisions Act nor any other statute in Ontario refers to living will, advance directives, there are not formal requirements for these documents, such as witnessing.

In clarifying this point, one informant stated: “A general living will is not considered as definitive as a power of attorney … it is however you, expressing your wishes and the latest wishes which must be respected.”\(^{52}\) This aspect of the law does not appear to be well understood throughout the Province.

The Alzheimer Society of Ontario and the Ontario Senior Secretariat have developed a strategy to assist the increasing number of older people to proceed with making decisions about their future care within the context of the current legislation. This Strategy for Alzheimer Disease and Related Dementias includes an “initiative” (Initiative # 7) on “Advance Directives on Care Choices.”\(^{53}\)

The background preparation for this particular initiative included extensive consultation and gathering information on issues related to advance directives in five areas: legislation, policy, education, current practice and contentious issues. Health professionals and seniors were consulted, and provincial legislation and advance directive legislation in other countries was studied, together with information about education programs and relevant policies. This consultation process forms the basis of an extensive education and training program in Ontario.\(^{54}\)

The results of these consultations are relevant for this discussion.\(^{55}\) In summary:

1. Much of the practice in Ontario has moved away from the legislation – practitioners have not really understood the law.
2. All Provinces now have legislation, but not all Territories.\(^{56}\)
3. There are still issues of portability, even though the legislation throughout Canada is fairly similar. Most provide for both the appointment of a substitute decision-maker and the expression of care wishes. It is not clear that the provincial legislation will be acceptable in other Provinces. For example, the legislation in Quebec is more prescriptive and there is more control (it refers to a “mandate in case of incapacity”). Alberta does not have forms – it uses a more flexible surrogate decision-maker model. It tends to set the precedent for the Ontario Government.
4. There is a lot of confusion around the different forms such as living wills and instructional directives (sometimes called “tools”). Instructional directives are also called “level of care” forms that are used on admission to an aged care facility (see discussion above). Some facilities insist that residents complete these forms on admission. If they are incompetent, then their proxy is expected to do so, but legally this is not appropriate. One feature commonly misunderstood is the fact that surrogate decision-makers cannot make an advance directive on behalf of another person. This issue has become a common problem in Ontario.\(^{57}\)
5. When the public is consulted they want written materials, but it has been acknowledged that written materials are not very effective.
6. The international scan of advance directive legislation and policy found that advance directives are a Western concept and seem to be culturally specific. Hence not all countries are doing work in this area.

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\(^{51}\) (2001) 13 (No 3) Advocacy Centre for the Elderly Newsletter. (ACE is a legal clinic serving low-income seniors.)

\(^{52}\) Interview, Toronto, 2001.


\(^{55}\) The key informant was the policy officer for this strategy. This is a summary of the major points from the interview, 2001.

\(^{56}\) See Appendix 2 below at 75.

\(^{57}\) It was also acknowledged as an issue by informants in British Columbia.
As a result of this consultancy, an education package was developed to attempt to inform health professionals and seniors about their rights under the current legislation. It is called the *Advance Care Planning Education Project*.\(^{58}\) This package embodies a holistic philosophy by:

- focusing on the life of a person;
- respecting a person’s choice and wishes, taking into account her or his values, beliefs, attitudes, feelings, likes, dislikes; right to self-determination; her or his culture, physical, psychological, socio-economic, functional strengths and limitations, and significant people in the person’s life;
- understanding that the conversation between the person and her or his family/substitute decision-maker is the most important step in advance care planning; and
- understanding that effective and ongoing communication between the person, substitute decision-maker, family, staff and others is essential.

The policy stresses the importance of effective communication. It does not support any “tool” (advance directive pro forma or the need for written instructions). It is a process for advance care planning which is more consistent with the legislation, as emphasised by one informant: “10 years of forms and they don’t work – it is a process, the conversation.”\(^{59}\)

**Advance care planning**

This shift towards advance care planning is also acknowledged in other sources, such as articles. Martin, Emanuel and Singer (Joint Centre for Bioethics) state:

> An important element of quality end-of-life care is advance care planning, “a process of communicating among patients, their health-care providers, their families, and important others regarding the kind of care that will be considered appropriate when the patient cannot make decisions”.

Advance care planning may, and generally does, include written advance directives (AD) forms.\(^{60}\)

However, these authors go on to say that empirical research shows that although patients and providers express a positive attitude towards advance directives, they seldom use the forms. In reporting other research on the effectiveness of advance directives (also referred to as “advance treatment preferences”), they quote Miles et al as saying: “Advance treatment preferences have been shown to be difficult to form, communicate and implement.”\(^{61}\)

Interviewees expressed ambivalent views on the concept of advance directives, although they tended to support the need for, and importance of, conversations, stating: “It is the conversation that counts”\(^{62}\) and “Advance care planning is an example of an initiative that has been largely unsuccessful because it was not grounded in the experiences of the individuals for whom it was intended.”\(^{63}\)

One interviewee stated:

> There are two concerns essentially. One is we don’t really have them (advance directives) and secondly when we do have them they don’t work… For all the years I have worked in the health care area I would have seen about 19 and out of those very, very few were useful… There is an enormous gap between attitude and behaviour – this fabulous idea. Why does it not translate into behaviour?

> … The best thing I have seen so far is advance care planning – encouraging conversations, the dialogue for the people who want to have them – not everyone does.\(^{64}\)

This person then went on to say that there are problems with the system:

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\(^{59}\) Interview, Toronto, 2001.


\(^{61}\) Martin, Emanuel and Singer, n 60 at 1672.

\(^{62}\) Interview, Toronto, 2001.

\(^{63}\) Interview, Toronto, 2001.

\(^{64}\) Interview, Toronto, 2001.
The other problem is the system – the system is very balanced towards the aggressive, end-of-life care with no clear goals other than keeping the person alive. The system has a way of driving itself – also people fear litigation …

… the system has a way of pushing itself, it has a life of its own – and there are market forces at play.\(^{65}\)

Several spoke of the lack of attention to cross-cultural issues and the way in which this extends beyond language, saying: “the philosophical question is not obvious to the people it’s being asked to, therefore it is irrelevant … they don’t know what you are getting at.”\(^{66}\)

The different concerns of people from non-Western cultures are not clearly addressed in the research and education material available or in the published literature. One study carried out with Chinese seniors in Toronto indicated that the concept of advance directives or of planning ahead about one’s dying is inappropriate and unacceptable.\(^{67}\)

**British Columbia: Similar but different**

In British Columbia there are similarities to Ontario but also significant differences in the ways in which older people are being encouraged to make decisions in advance. One important difference is in nomenclature – the language. The main focus in this Province is on appointing a representative who is a substitute decision-maker, that is, a “proxy”. The Public Guardian and Trustee of British Columbia booklet, *It’s Your Choice: A Guide to Making a Representation Agreement*, states:

Four new laws in BC ensure that our rights and wishes will be respected, even if we are unable to make our own decisions. The New Laws are:

- the *Representation Agreement Act*
- the *Health Care (Consent) and Care Facility (Admission) Act*
- the *Adult Guardianship Act,* and
- the *Public Guardian and Trustee Act*.\(^{68}\)

The *Representation Agreement Act 1996* (BC) grew out of a community movement as a result of general dissatisfaction with the guardianship and mental health legislation. Thirteen groups of people with a range of disabilities were involved. They worked together to establish key principles for the care of those people with limited decision-making abilities, including seniors concerned about end-of-life decisions and the potential for deteriorating competence because of dementia. The purpose of the Act is:

(a) to allow adults to arrange in advance how, when and by whom, decisions about their healthcare, personal care or financial affairs or about other matters will be made if they become incapable of making decisions independently, and

(b) to avoid the need for the court to appoint someone to help adults make decisions, or someone to make decisions for adults, when they are incapable of making decisions independently.\(^{69}\)

The Act stipulates that an adult who makes a “standard” representation agreement may name another adult, the Public Guardian and Trustee, or a credit union or trust company. The latter can only be responsible for financial, business and legal matters. This means that another representative can be appointed but a specific area of decision-making authority has to be named.

The *Representation Agreement Act* covers decisions about health care, including the refusal of life support, personal care, financial matters, property decisions such as selling a house, and business and legal affairs. This type of agreement gives the representative the maximum powers and flexibility to handle the grantor’s affairs. A lawyer is required to sign a certificate to authenticate this agreement

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\(^{65}\) Interview, Toronto, 2001.


between two people. The “standard agreement” covers decisions of less significance and does not necessarily involve a lawyer.

The Public Guardian and Trustee information states that living wills/advance directives were previously not legal documents in British Columbia but, with the introduction of the Representation Agreement Act 1996 and the Health Care Consent Act 2000, these documents are now given certain legal effect.

In 2002 the government commissioned Professor A MacLean QC of the Faculty of Law at the University of British Columbia to write a report on the Representation Agreement Act and the Power of Attorney Act. The recommendations are currently being examined and may result in changes to both statues in due course.

The Representation Agreement Resource Centre has been established to educate seniors in British Columbia about this Act. This has been established mostly by volunteers to assist people in understanding their rights under the Act. It provides printed material but does not give legal advice.

The legal instruments are complex and the decision to delegate all decision-making responsibility can be daunting for a frail older person. It means appointing only one person to take care of all their decisions while they are still competent to do so. On the one hand, this requires placing great trust in the representative, while on the other hand, it places considerable responsibility on that representative.

The law in British Columbia is moving towards appointing one substitute decision-maker, a representative for all decisions – financial, personal care and health care. The aim of the legislation is to simplify the substitute decision-making model and to protect all vulnerable people, but it will take time for the community, legal and health professionals to understand the nature of the law and the language. It is questionable whether the term “advance directives” will continue to be appropriate in British Columbia. Currently it has the potential to create confusion both in the Province and across the nation.

CONCLUSION

A number of themes emerge from this brief exploration of some of the issues associated with the law and practice of advance directives in Canada and Australia. The most notable of these is the lack of consistency and clarity about the terminology both within the Provinces and across the nation of Canada, and to a lesser degree in Australia. The lack of clarity and consistency which surrounds the language and the meaning of the various terms can be a barrier for people wanting to express their wishes in advance, especially for older people for whom this concept is most pertinent.

There are also a number of issues that emerge about “advance directive” legislation. The evidence from previous research indicates that written directives (living will forms) for refusing medical treatment in advance, whether legal documents or not, are difficult to design and very few people actually use them. There is no such thing as a perfect “living will” form that will cover all contingencies and cater to people’s different personal preferences. These forms are difficult to write, interpret and implement. There are similar issues associated with appointing a medical power of attorney to make the decisions about refusal of medical treatment, especially in some jurisdictions where the attorney (agent) is expected to follow the grantor’s written wishes.

“Ten years of forms and they don’t work – it is a process, the conversation.” Similar statements were often repeated throughout the study: hence the move in Canada towards what is now being called “advance care planning”. Legislating for advance care planning shares many of the same dilemmas that have been discussed in this article.

A fundamental question to emerge from this discussion is: to legislate or not to legislate? If the decision is to legislate, then what type of legislation is most appropriate? As discussed in this article,
there are considerable differences between the Consent to Medical Treatment and Palliative Care Act 1995 (SA) and the Representation Agreement Act 1996 (BC). The former could be described as health law, where the Schedules only refer to decisions about refusal of medical treatment, while the latter encompasses all decisions that may have to be made when a person’s capacity is deteriorating. This includes turning off life support and selling the house.

It would appear that the momentum towards using advance directives is not so pronounced in Australia. Some Australian jurisdictions are moving in a similar direction but still not encompassing all areas of decision-making. Queensland has included the health directive within the powers of attorney legislation, for example, while South Australia and New South Wales have enduring powers of guardianship under the guardianship legislation, which encompasses decisions about the individual’s personal and health care, but not financial matters.

Canada has adopted a substitute decision-making model across the country but the provincial laws backing this position vary, use different terms and have different powers. Australia is moving more tentatively towards this approach. Further research, debate and dialogue are required to clarify if this is the most appropriate direction to follow to protect all vulnerable citizens, and, for the purpose of this discussion, older people as they face frailty and death. The debate should not be confined to the legal profession or the medical profession. It needs to encompass all current societal values. It would also be relevant to include a comparative study with the United Kingdom where, as yet, there are no specific laws in the area of advance directives but there is guardianship legislation to protect vulnerable people.

Seeking guidance on how to express one’s wishes about future incompetence and how to talk about one’s death is important as people age. Uncertainty about whom to have these conversations with – a doctor, a lawyer or a close relative – was one theme to emerge from this research. When legislation exists, there is an expectation that the most appropriate professional guidance will be from a lawyer. However, this raises concerns about the medical decisions that have to be considered. The current situation in Canada and Australia indicates that an older person might need to seek counsel from both a lawyer and a doctor. This creates an additional barrier, even without considering the expense.

Finally, the concept of “advance directives”, of thinking ahead about one’s ultimate demise and how to express one’s wishes whilst still competent, does not just belong to medicine or the law. It is about values, both individual and societal. It is about dying and death. The term “advance directive” can be interpreted as a metaphor – a metaphor for death. It provides a language for people, including health professionals, to discuss some of the issues about death. The findings in this article suggest that the metaphor is changing and no longer relates only to the refusal of medical treatment in advance of incompetence. It now encompasses the decisions individuals may wish to make about their life as it draws to an end, and when they can no longer communicate.

It is this metaphor that has to be discussed more openly and acknowledged in Canada and Australia. The conversations are what count – conversations about death that need to be encouraged so we can all move on from denying its existence.
## APPENDIX 1. ADVANCE DIRECTIVE/PROXY LEGISLATION – AUSTRALIA*

<table>
<thead>
<tr>
<th>State/ Territory</th>
<th>Advance Directive/ Refusal of Treatment</th>
<th>Proxy/ Agent: Patient Appointed</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>No</td>
<td>No</td>
<td>No current legislation for advance directives or proxies. Department of Health has guidelines “Dying with Dignity” which direct respect for previously stated wishes. Enduring guardian legislation passed January 1999.</td>
</tr>
<tr>
<td>South Australia</td>
<td>Yes</td>
<td>Yes</td>
<td>Consent to Medical Treatment and Palliative Care Act 1995 (SA) provides that a person over 18 years can write advance directive any time (ie, anticipatory) but only for terminal illness. The Act also allows for appointment of an agent to make decisions about medical treatment, including withdrawing or withholding life-sustaining measures, but not refusal of the natural provision/administration of food and water, or pain-relieving drugs.</td>
</tr>
<tr>
<td>Tasmania</td>
<td>No</td>
<td>No</td>
<td>No current legislation. Tasmania also has “Dying with Dignity” guidelines.</td>
</tr>
<tr>
<td>Victoria</td>
<td>Yes</td>
<td>Yes</td>
<td>Medical Treatment Act 1988 (Vic) allows a patient to write a ‘refusal of treatment’ certificate, but only for a current illness which does not have to be terminal (ie not anticipatory). Medical Treatment (Enduring Power of Attorney) Act 1990 (Vic) allows appointment of agent (proxy) and the Medical Treatment (Agents) Act 1992 (Vic) allows appointment of an alternate agent.</td>
</tr>
<tr>
<td>Western Australia</td>
<td>No</td>
<td>No</td>
<td>No current legislation. Private Members Bill for refusal of treatment by terminally ill people (Medical Care of the Dying Bill 1995 (WA)) passed by Lower House November 1995, lapsed when election was called. The Bill recommended patients be allowed to refuse palliative care.</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>Yes</td>
<td>Yes</td>
<td>Medical Treatment Act 1994 (ACT) allows refusal of treatment but only for a current illness which does not have to be terminal (as for Victoria) and appointment of proxy, who may consent to withdrawing/withholding of life-sustaining measures. Protects health professionals who withhold/withdraw treatment at patient’s or attorney’s request.</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Yes</td>
<td>No</td>
<td>Natural Death Act 1988 (NT) allows a person 18 years or over to write an advance directive at any time, but it applies only to a terminal illness (as for South Australia).</td>
</tr>
</tbody>
</table>

* As at 26 October 2001. All States and Territories have guardianship legislation.

### APPENDIX 2. ADVANCE DIRECTIVES – RELEVANT CANADIAN PROVINCIAL AND TERRITORIAL LEGISLATION

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Relevant legislation</th>
<th>Language used to describe advance directive</th>
<th>Provision for proxy directive</th>
<th>Provision for instruction directive</th>
<th>Proxy appointment Hierarchy if not appointed</th>
<th>Proxy’s authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newfoundland</td>
<td>Advance Health Care Directives Act 1995</td>
<td>Advance health care directive</td>
<td>Yes Proxy: 19y+ May have +1 proxy</td>
<td>Yes Maker: 16y+</td>
<td>Yes Health care decisions involving physical, mental, health, personal care.</td>
<td></td>
</tr>
<tr>
<td>PEI</td>
<td>Consent to Treatment and Health Care Directives Act 1996</td>
<td>Health care directive</td>
<td>Yes Proxy: 16y+ May have +1 proxy</td>
<td>Yes Maker: 16y+</td>
<td>Yes Health care decisions.</td>
<td></td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>Medical Consent Act 1989</td>
<td>Not specified</td>
<td>Yes Proxy: 19y+</td>
<td>N/A</td>
<td>Consent to medical treatment or directions re medical treatment.</td>
<td></td>
</tr>
<tr>
<td>New Brunswick</td>
<td>None currently in place</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Quebec</td>
<td>Quebec Civil Code 1991</td>
<td>Mandate</td>
<td>Yes Proxy: 18y+ May have +1 proxy</td>
<td>Yes Proxy: 18y+ (limited)</td>
<td>Yes Consent for medical care.</td>
<td></td>
</tr>
<tr>
<td>Manitoba</td>
<td>Health Care Directives Act 1993</td>
<td>Health care directive</td>
<td>Yes Proxy: 18y+ May have +1 proxy</td>
<td>Yes Maker: 16y+</td>
<td>Yes Health care decisions.</td>
<td></td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>Health Care Directives and Substitute Health Care Decision Makers Act 1997</td>
<td>Health care directive</td>
<td>Yes Proxy: 18y+ May have +1 proxy</td>
<td>Yes Maker: 16y+</td>
<td>Yes Health care decisions.</td>
<td></td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Relevant legislation</td>
<td>Language used to describe advance directive</td>
<td>Provision for proxy directive</td>
<td>Provision for instruction directive</td>
<td>Proxy appointment Hierarchy if not appointed</td>
<td>Proxy’s authority</td>
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</tr>
<tr>
<td>Alberta</td>
<td>Personal Directives Act 1996</td>
<td>Personal directive</td>
<td>Yes Proxy: 18y+ May have +1 proxy</td>
<td>Yes Maker: 18y+</td>
<td></td>
<td>Personal decisions (may give, refuse or withdraw health care treatment).</td>
</tr>
<tr>
<td>British Columbia</td>
<td>Health Care (Consent) and Care Facility (Admission) Act 1993 Representation Agreement Act 1996</td>
<td>Representation agreement (RAA)</td>
<td>Yes Proxy: 19y+ (RAA) If more than 1 proxy, must have principal proxy or different areas of authority May appoint a monitor to ensure that proxy is doing their job</td>
<td>Yes Maker: 19y+ (RAA)</td>
<td>Yes (HCCF)</td>
<td>Health and personal care decisions (RAA).</td>
</tr>
<tr>
<td>Nunavut</td>
<td>None currently in place</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>NWT</td>
<td>None currently in place</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Yukon</td>
<td>None currently in place</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>