



Resources

- **Consent to care**
[quebec.ca/en/family-and-support-for-individuals/
incapacity-loss-independence/consent-care-incapacity](https://quebec.ca/en/family-and-support-for-individuals/incapacity-loss-independence/consent-care-incapacity)
- **Advance medical directives**
[Advance medical directives | Gouvernement du Québec
\(quebec.ca\)](https://quebec.ca/advance-medical-directives)
- **Educaloi**
educaloi.qc.ca/en/publications/caregivers-practical-legal-tools
- **L'Appui**
lappui.org/fr/je-suis-aidant/
- **Ligne Info Notaire**
1-800-notaire (668-2473)
- **Portail Santé Montérégie**
[Palliative and end-of-life care](https://santemonteregie.qc.ca/palliative-and-end-of-life-care)
- **Advance care planning**
advancecareplanning.ca
- **Palliative care**
[Palliative care: Preparing and deciding - Canada.ca](https://palliativecare.ca/preparing-and-deciding)

Your advance care wishes

Reflection and decision-making guide

TO BETTER GUIDE YOU



santemonteregie.qc.ca/ouest

Throughout life, we all face moments that require us to make choices about our health and well-being. There are many different diseases—some curable, some incurable. When a disease reaches an advanced or terminal stage, it progresses in a way that shortens life expectancy. As this happens, you may find yourself thinking about the type of care you want, including palliative care and end-of-life care.

Did you know that most people have thought about their wishes and the type of care they would like to receive?

However, very few have shared their concerns and decisions with their loved ones. Having open conversations can help others understand what truly matters to you and make it easier for them to support and respect your choices when the time comes.

This document is designed to introduce you to the different tools and key concepts that can help you reflect on, make decisions about, and communicate with your loved ones and care team about:

- The type of care you want—or do not want—to receive.
- Who will make decisions on your behalf if you are unable to decide for yourself or express your wishes.



Whether you are healthy or ill, and throughout all stages of a disease, these reflections and discussions can help prepare you and your loved ones for different health situations. Being well-informed allows you to make thoughtful decisions.

Let's start by clarifying some key concepts

Consent

Consent to care: Expression of the person's wishes regarding an act to be performed by the care team.

Consent to care and services must be **voluntary** and **informed**.

- **Voluntary consent:** Without any form of pressure or discrimination by the professional, caseworker, person's family or loved ones. The person gives their consent with complete confidence.
- **Informed consent:** Having all the appropriate and necessary information, which they understand, and having been informed of the consequences of their consent, the user consents with full knowledge of the facts.

Capacity or ability to give consent

You are considered capable of consenting to a medical treatment if you can understand:

- the information necessary to make a decision about your treatment;
- the consequences and risks associated with your decision.

You may be capable of making certain decisions (e.g., deciding what you want to eat or drink) while being incapable of making others (e.g., consenting to surgery). Your ability to give consent can also vary from day to day.

The health professional giving the treatment is responsible for determining whether the person is capable of giving consent.

Civil Code of Québec, sect. 10, 11, 13, 15 and 16
legisquebec.gouv.qc.ca/en/document/cs/CCQ-1991

Representative

User representative: A designated person who is authorized to give consent to care in the event you are incapable of doing so because of your state of health.

When do you need a representative?

When you have been deemed incapable of consenting to care.

What is the role of the representative?

To make care decisions on your behalf, always with your best interests in mind.

Who can be your representative?

- 1st: Your tutor or mandatary
- 2nd: Your married, civil union or de facto spouse
- 3rd: A close relative or a person who shows a special interest in your well-being

Recommended reflection and decision-making tools

Advance care planning



Goal: Think about and write down your wishes

Website: advancecareplanning.ca

Advance care planning (ACP) is a process of thinking about and discussing your wishes and preferences with loved ones and your representative, who will speak on your behalf if you become incapable of doing so.

Thinking ahead and sharing your wishes in the event of a major change in your health condition will help your loved ones and care team honour them when the time comes. This process includes decisions about the type of end-of-life care and services you want to receive.

ACP can also involve writing down your wishes with the help of professionals (e.g., notaries, accountants).

Here is a five-step method for creating a personalized plan:

1. **Think about** your personal wishes and preferences. For example:
 - Consider what aspects of end-of-life care are most important to you.
 - What end-of-life treatments would you want to receive?
 - What treatments would you refuse? (e.g., resuscitation, feeding tubes, blood transfusions)
 - How would you like your final days and weeks to unfold?
 - Do you have concerns about end-of-life care (e.g., pain management, loss of autonomy)?
2. **Gather information:**
 - About how your health condition is likely to progress and deteriorate.
 - About the available care and services (e.g., at-home or residential end-of-life care, continuous palliative sedation therapy).
3. **Designate** a trusted representative to make decisions on your behalf if you become incapable of doing so.
4. **Talk** to your loved ones, your representative, and your care team. Make sure they fully understand your wishes
5. **Confirm** your wishes and preferences directly with your care team or in formal documents (e.g., advance medical directives, level of care, living will).

Advance medical directives



Purpose: To ensure health professionals and loved ones respect your wishes in specific medical situations

Website: quebec.ca and enter “advance medical directives” in the search bar

There are several ways to express your wishes about the type of medical care you want to receive, including talking to loved ones or hiring a notary to prepare a formal document (e.g., a living will or other document).

In Québec, a legally binding document forces loved ones and care providers to respect the wishes of the person who completed it. The “Advance medical directives” form allows individuals to state in advance which of five specific medical treatments they would accept or refuse in certain clinical situations.

Clinical situations	Items of care
<ul style="list-style-type: none">• End-of-life situation: a serious and incurable medical condition, end-of-life patient.• Situation in which cognitive functions are severely and irreversibly compromised: an irreversible coma or a permanent vegetative state• Other situation in which cognitive functions are severely and irreversibly compromised, with no possibility of improvement (e.g., advanced-stage Alzheimer’s-type dementia or other type of dementia).	<ul style="list-style-type: none">• Cardiopulmonary resuscitation• Ventilator-assisted breathing or breathing assisted by another device• Dialysis• Forced or artificial feeding• Forced or artificial hydration



Important

Only a person of full age who is capable of giving consent to care can complete their advance medical directives. These directives will be used only if the person becomes incapable.

Individuals who wish to document their advance medical directives can do so:

- By filling out the Advance Medical Directives in Case of Incapacity to Consent to Care form:
 - available from the Régie d’assurance maladie du Québec (RAMQ) at 1-800-561-9749 (toll-free) | ramq.gouv.qc.ca
 - in a notarial deed whose content is the same as that of the advance medical directives (fees apply).

Levels of care and cardiopulmonary resuscitation



Purpose: To determine care and treatments with the care team

Website: santemonteregie.qc.ca and enter “levels of care” in the search bar

This document is used during healthcare discussions to outline treatment objectives, including decisions about cardiopulmonary resuscitation. It helps guide conversations when determining suitable medical treatments. The decisions made during this discussion will be recorded in a formal document and placed in your medical record. A copy may be given to you.

During these conversations, the doctor will explore the different options with you or your representative (in the event you are incapable):

1. If you have a respiratory or cardiac arrest, would you want to be resuscitated? You must answer “yes” or “no” to these questions.

- Attempt CPR Yes No
 Attempt emergency intubation Yes No

2. What level of care do you want? You must select the level of care that best aligns with your wishes.

Level of care	Descriptif
Goal A Prolong life with all necessary care	The care team will provide all interventions that are medically appropriate and transfer you if the intervention is not available in the current setting.
Goal B Prolong life with some limitations to care	Care incorporates interventions with the aim of correcting deterioration in health status while preserving quality of life.
Goal C Ensure comfort as a priority over prolonging life.	Your comfort is prioritized through the management of symptoms. Interventions to correct certain reversible health problems may also be used.
Goal D Ensure comfort without prolonging life	Care is exclusively aimed at maintaining your comfort through the management of symptoms.

If there is a change in your health condition, the doctor will adjust the care based on your choices or those of your designated representative in the event of your incapacity.

Your decisions about levels of care and cardiopulmonary resuscitation are not final. You can change your mind and your decisions at any time. After you have spoken to the doctor, the old form will be replaced with a new one reflecting your updated wishes. This process does not replace verbal consent to care.

Condition with a guarded prognosis

If you are facing a progressive or serious illness, the Government of Canada website contains valuable information to help you start thinking about and preparing for palliative care. This site explains the general concepts of palliative care, including important questions to ask your care team to better understand your condition and what to expect moving forward.

See:

- [Palliative care: Preparing and deciding - Canada.ca](#)
- [Three sets of questions to ask your health care team - Canada.ca](#)

To learn more about palliative and end-of-life care resources at the CISSS de la Montérégie-Ouest, we encourage you to consult the [Palliative and end-of-life care](#) brochure.

In summary

Reflections and discussions are important at every stage of life. Keep in mind that various health events may require adjustments in care plans. It is important to review these decisions periodically.

Regardless of your questions, reflections, or the decisions you need to make, your doctor and care team are here to support you.

Key concepts

Feeding and hydration (artificial): When a person can no longer eat or drink, fluids or food may be given through an intravenous infusion or a feeding tube placed in the stomach.

Tutor: A person appointed by the court to care for or manage the patrimony of an incapable user.

Intubation and ventilator-assisted breathing: When a person is unable to breathe on their own, a breathing tube (intubation) is inserted in their lungs through their mouth. This tube is connected to a ventilator, which breathes for the person (ventilator-assisted breathing).

Mandatory: A person designated to represent an incapable user in a protection mandate.

Protection mandate: A legal document that allows someone to make decisions on behalf of an incapable user.

End-of-life plan: A document or set of reflections outlining personal preferences and wishes to guide loved ones and health professionals in providing palliative care.

Guarded prognosis: Unfavourable prognosis related to the progression of a disease or the severity of injuries, suggesting that the person's long-term chances of survival are uncertain.

Cardiopulmonary resuscitation: A procedure aimed at restoring normal breathing after cardiac arrest, involving airway clearance and chest compressions.

Comfort care: Care provided when curative treatments are no longer effective. Medications or non-invasive treatments are used to ensure comfort. A person receiving comfort care is not necessarily at the end of their life.

End-of-life care: Care provided in the final weeks or days of life, focusing on relieving discomfort and ensuring well-being.

Palliative care: Combination of treatments provided by an interdisciplinary team for individuals with a guarded prognosis. Palliative care aims to relieve physical, psychological, and spiritual suffering without hastening or delaying death. It supports maintaining the best possible quality of life and provides necessary assistance to both patients and their loved ones [Gouvernement du Québec, 2017]. Palliative care includes its final phase: end-of-life care.



Notes

References:

- *Civil Code of Québec*, Article 15, 1991, c. 64, a. 15; 2002, c. 6, a. 1; 2014, c. 2, a. 67; 2020, c.11, a. 254.
- Politique clinique - Consentement aux soins et aux services POL-10251 (2021-09) CISSS de la Montérégie-Ouest