



Consent to Treatment: Frequently Asked Questions

1. Does the *Health Care Consent Act, 1996 (HCCA)* specify an “age of consent” for treatment?

No. The *HCCA* does not specify an age at which a minor is capable of providing consent to treatment, nor does the *HCCA* define “minor”.

As stated in the College’s policy, the test of capacity to consent to treatment is a functional test and is not age-dependent. The *HCCA* and the College’s policy state that a patient is capable with respect to a treatment if they are able to understand the information that is relevant to making a decision about the treatment, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. The same test for capacity applies to both minors and adults.

2. Are there any resources regarding consent to treatment that minors and their families might find helpful?

Physicians may want to consider referring minors and their families to existing resources, such as the Provincial Advocate for Children & Youth’s *The Ultimate Health Rights Survival Guide: A step-by-step guide for young people for making your own health decisions and what to do when you can’t make your own decisions.*

3. My patient is refusing to consent to a treatment that I think they should have. Does this mean they are incapable?

No. Patients and substitute decision-makers (SDM) have the legal right to refuse, withhold or withdraw consent. Patients or SDMs may sometimes make decisions that are contrary to the physician’s treatment advice. Physicians cannot automatically assume that because the patient or SDM is making a decision they do not agree with, that they are incapable of making that decision.

While a refusal to consent to a recommended treatment is not automatic grounds for a finding of incapacity, it is possible that a patient’s decision that is contrary to a physician’s advice may cause the physician to question whether the patient has the capacity to make the decision (e.g., the physician is concerned that the patient may not truly understand the consequences of not proceeding with the treatment). Where this is the case, the physician may want to consider doing a more thorough investigation of the patient’s capacity to ensure the patient’s decision is informed and valid.

4. The College’s policy advises physicians to consider and address language and/or communication issues (e.g., physician and patient do not speak a common language, patient is deaf or has difficulty speaking/communicating, patient has a cognitive impairment, etc.). What resources or techniques can I use to help overcome these issues?

Physicians may want to consider using the following resources or tools to help overcome any language and/or communication issues:

- Family members or third party interpreters.
- Speech language pathologists.
- Occupational therapists.
- Communication techniques.
 - Writing
 - Typing
 - Non-verbal communication (e.g., hand squeezing, blinking, etc.)

5. The College’s policy requires that physicians take reasonable steps to facilitate the comprehension of the information provided. What factors limit comprehension? What steps should be taken to facilitate the comprehension of information?

There are a number of factors that may limit comprehension, including, but not limited to:

- Language and communication issues (as described in Question 4).
- Literacy issues, including issues with numerical literacy (e.g., difficulty understanding probabilities) and medical literacy (e.g., difficulty understanding medical terms).
- Preferences for different learning modalities (e.g., visual, auditory, etc.).
- Presence of pain, mood disorders, or biases (e.g., heightened emotion, focusing on short-term concerns, being influenced by unrelated past events, etc.).
- Lack of time (e.g., not allowing for time to process/consider the information).

To help facilitate the comprehension of the information provided, physicians may want to:¹

¹ Adapted from the Canadian Medical Protective Association’s document, “Helping patients make informed decisions” (April 2014). Available at: https://opfrpd5.cmpa-acpm.ca/en/duties-and-responsibilities/-/asset_publisher/bFaUiyQG069N/content/helping-patients-make-informed-decisions.



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- Consider whether there are any language or communication issues that need to be addressed (see response to Question 4 for resources and tools).
- Consider the patient's numerical and medical literacy and help him or her understand probability data and/or use plain language.
- Discuss with the patient how he or she prefers to receive information (e.g., format, level of detail, etc.).
- Ask the patient if he or she would like a family member, friend, or other health-care provider to participate in the dialogue.
- Adapt the dialogue to the circumstances and severity of the diagnosis.
- Explore the patient's goals and values.
- Explore with the patient the level of risk considered acceptable in light of their goals and values.
- Listen and respond to the patient's ideas, concerns, and expectations about their health.
- Present or direct the patient to credible sources of information about their condition and the treatment options (e.g., hospital library, web resources, pamphlets, etc.).
- Consider the use of decision aids that may help the patient better understand and weigh the options.
- Consider the presence of pain, mood disorders and biases when communicating information.
- Consider a phased approach, granting the patient an opportunity to absorb the information before a decision is required.

6. How can I encourage patients and SDMs to ask questions?

Physicians can help encourage patients and SDMs to ask questions by creating a positive environment where questions are encouraged by implementing the following strategies:

- Scheduling enough time for the appointment to allow for questions.
- Inviting questions throughout the dialogue.
- Using open ended language such as "what questions do you have for me?".
- Arranging a time to answer any questions that arise after the appointment.

7. What should I do if a patient or SDM waives their right to be informed and wants to provide consent without hearing about the risks?

Patients or SDMs may feel anxious about the proposed treatment and may not want to hear about the risks.

It is a key legal requirement that in order for an individual to provide a valid consent, he or she must be informed. As such, physicians are required to provide information about the

nature of the treatment, its expected benefits, its material risks and material side effects, alternative courses of action, and the likely consequences of not having the treatment. If a patient or SDM refuses to hear this information, their decision will not be informed and their consent will not be valid.

Physicians may want to sensitively explain this requirement to the patient or SDM, and emphasize the importance of understanding the risks. Physicians may also want to give patients or SDMs time to process the information, and try to arrange for an opportunity to continue the dialogue at a later date.

If the patient or SDM continues to refuse to hear about the risks, the physician may want to seek legal advice regarding how to proceed.

8. In order to obtain informed consent, I must provide certain information, including the "material risks" associated with the treatment. What are "material" risks and which risks do I have to disclose?

Courts have defined a "material" risk as a risk that a reasonable person in the same circumstances as the patient would want to know in order to make a decision about the treatment. This will include, but is not limited to, disclosing risks that the physician believes may lead the patient to refuse or withhold consent to treatment.

Generally speaking, the more frequent the risk, the greater the obligation to inform the patient about it. In addition, risks of great potential seriousness, such as paralysis or death, must likely be disclosed even if uncommon.

The particular circumstances of the patient are crucial to determining whether a risk is material to a reasonable person in the position of that patient. Therefore, the risks that must be discussed with each patient may well vary and must be determined on a case-by-case basis. Physicians must apply their clinical judgment to determine what risks are "material" with respect to any treatment proposed to a particular patient.

9. If a patient or SDM reviews and signs a consent form do I also need to have a dialogue with them about the risks associated with the treatment?

A signed consent form does not replace a dialogue with the patient or SDM.

The College requires physicians to engage the patient or SDM in a dialogue about the nature of the treatment, its expected benefits, its material risks and material side effects, alternative courses of action, and the likely consequences of not having the treatment. This requirement to have a dialogue with the patient or SDM exists regardless of whether or not physicians use supporting documents such as consent forms, patient education materials or pamphlets, etc.



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10. Can obtaining consent be delegated to other health-care providers (e.g., nurses, residents, etc.)?

The obligation to ensure that valid consent has been obtained always rests with the physician who is proposing the treatment. Physicians who delegate² the task of obtaining consent to other health-care providers must only do so when they are assured that the health-care provider has the knowledge, skill and judgment required to obtain consent.

For example, physicians must be assured that the health-care provider has the knowledge skill and judgment required to engage the patient or SDM in a dialogue regarding the treatment, provide a response to requests for additional information about the treatment, and to be satisfied that information about the treatment was understood by the patient or SDM.

11. The College's policy requires that I document information about the material risks associated with the treatment. Which risks do I have to document?

The policy states that a legible, understandable and contemporaneous note in the patient's record regarding consent to treatment is the best evidence a physician has to demonstrate that the requirements of the *HCCA* have been satisfied.

Physicians must use their professional judgment to determine what information to document in the patient's record, taking into consideration the specific circumstances of the case. However, the College recommends noting the specific material risks that were communicated and any unique material risks related to the specific circumstances of the patient that were communicated. This may include, but is not limited to, documenting the risks that may lead the patient to refuse or withhold consent to the treatment.

12. The College's policy states that physicians have a legal obligation to ensure that SDMs understand the requirements for giving or refusing consent as set out in the *HCCA*. What steps should be taken to fulfill this obligation?

It depends. Physicians will need to determine how familiar the SDM is with the *HCCA* requirements. Some SDMs may not know what the requirements set out in Section 21 of the *HCCA* are, so physicians may need to tell them. Physicians may want to consider referring SDMs to existing substitute decision-making resources that outline the requirements, such as the Hamilton Health Sciences' Making Decisions for Others: Your Role as a Substitute Decision Maker education document.

Other SDMs may be very familiar with the requirements, as they may have had to give or refuse consent on behalf of an incapable patient before. In these circumstances, physicians

may not need to tell SDMs what the requirements are. Instead, physicians must be satisfied that the SDM understands what the *HCCA* requirements are when they are obtaining consent to a treatment from an SDM.

If physicians are of the view that the SDM is not acting in accordance with the *HCCA*, they may apply to the Consent and Capacity Board for a determination.

13. If consent has been obtained for a treatment (including a plan of treatment) and a minor change to the treatment is necessary or the location of treatment is changed, does consent need to be obtained for the change?

No. The *HCCA* and the College's policy state that unless it is not reasonable to do so in the circumstances, physicians are entitled to presume that consent to treatment includes:

- consent to variations or adjustments in the treatment, if the nature, expected benefits, material risks and material side effects of the changed treatment are not significantly different; and
- consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks or material side effects of the treatment as a result of the change in the setting in which it is administered.

Physicians must use their professional judgment to determine whether or not the change they are considering would be captured by either of these provisions.

14. Are there resources to help me navigate the consent process?

To assist physicians, the College's policy contains a high-level overview of the framework and key requirements for consent to treatment, which have been provided in chart form (see page 4 of policy). Physicians may also wish to refer to the Ontario Hospital Associations' Decision Tree for Obtaining Consent Under the *Health Care Consent Act*³ to be a helpful resource for navigating the consent process.

If physicians are unsure of their legal obligations in specific circumstances, the College advises them to obtain independent legal advice from the Canadian Medical Protective Association or other legal counsel.

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² The term delegation is used here in the colloquial sense; it does not refer to the delegation of controlled acts, as defined in the College's Delegation of Controlled Acts policy.

³ See Appendix A of the Ontario Hospital Associations' A Practical Guide to Mental Health and the Law in Ontario.