

Consent to Medical Treatment

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REFERENCE MATERIALS:	<i>Consent: A Guide for Canadian Physicians, Third Edition, The Canadian Medical Protective Association, 1996; A Guide to the Health Care Consent Act, CPSO, 1996; Consent to Treatment: A Brief Overview of the Law in Ontario, Michael Bay, 1998</i>
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CPSO POLICY STATEMENT

Consent to Medical Treatment

PURPOSE

The purpose of this document is to clarify when and how a physician can obtain a patient's consent to treatment and what constitutes consent.

PRINCIPLES

1. The best interests of the patient are central to all physician-patient interactions.
2. Respect for the autonomy and personal dignity of the patient is central to the provision of ethically sound patient care. Through the translation of these ethical principles to law, the Supreme Court of Canada has confirmed the fundamental right of the individual to decide which medical interventions will be accepted and which will not.¹
3. In order to exercise their autonomy, patients must be capable of making informed decisions about their health care.
4. The goals of the *Health Care Consent Act (HCCA)* include promoting individual autonomy and decision-making capacity, and facilitating communication between health care practitioners and their patients.
5. Physicians have the obligation to secure consent and patients have the legal right to either consent to or refuse treatment.

DUTIES

The duties set out below are codified in the *Health Care Consent Act*.² This document does not summarize the *Act* in its entirety³ and physicians are encouraged to consult the *Act* in order to familiarize themselves with all the legislative provisions.

Briefly, the following must occur when a physician proposes a treatment:

- The physician determines if a patient is capable of consenting. If the patient is capable, the physician must provide information about the treatment. The patient either provides consent or refuses the treatment. If the patient consents, then the physician proceeds with the treatment until the patient's capacity changes or the treatment changes.
- If the patient is determined to be incapable, then the physician must identify the substitute decision-maker, and go through the same process to obtain consent.

These processes will be explained in greater detail below.

A. NON-EMERGENCY SITUATIONS

Determining Capacity

A person has capacity if that person is capable of consenting to treatment. The person must be able to understand the information that is relevant to making a decision about



¹ *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119.

² An electronic version of the *HCCA* can be found at: http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/96h02_e.htm. The *HCCA* does not affect the law relating to consent on another person's behalf with respect to procedures whose primary purpose is research, sterilization that is not medically necessary, and removal of tissue for transplantation. It also does not affect the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to that person or others. Sections 6 and 7 of the *HCCA*.

³ This policy does not address the portions of the *HCCA* that regulate Admission to Care Facilities and Personal Assistance Services. The policy only deals with '**consent to treatment**'.

the treatment and must be able to appreciate the reasonably foreseeable consequences of a decision or a lack of decision.⁴

A physician must determine that a patient is capable of giving consent and must obtain consent from a patient before providing treatment. A physician is entitled to assume that a patient is capable of giving consent unless there are reasonable grounds to believe otherwise.⁵ For example, there could be something in a patient's history or behaviour that would make a physician question the patient's capacity to consent. But, if a patient knows who they are, where they are, what is being proposed, and the consequences of the decision they are being asked to make, it is likely safe for a physician to rely on the presumption that the patient is capable.

Capacity is not static – it can change over time and be different depending on the nature and complexity of the specific treatment decision. What is being determined is whether the patient has the ability to understand the nature and effect of the treatment being proposed, not the “global” capacity of the person.

Two things can trigger the consent to treatment process: (1) when a treatment is proposed or there is going to be a change in the treatment, and (2) there is a change in the person's ability to understand the nature and effect of the treatment.

A patient who is capable of providing consent is also capable of withdrawing consent to the treatment.⁶

The policy also explains what a physician must do if he or she determines that a patient is incapable. This is discussed in detail below.

Minors

The *Act* does not identify an age at which minors may exercise independent consent for health care because the capacity to exercise independent judgment for health care decisions varies according to the individual and the complexity of the decision at hand. Physicians must make a determination of capacity to consent for a child just as they would for an adult.

ELEMENTS OF CONSENT

Four conditions, which are explained in detail below, must be present in order for consent to treatment to be valid:

1. Consent must be related to treatment

Subsection 2 (1) of the *HCCA* sets out the definitions which apply to consent to treatment.

‘Treatment’ is “anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan...”

‘Course of treatment’ is “a series or sequence of similar treatments administered to a person over a period of time for a particular health problem.”

⁴ Subsection 4 (1) of the *HCCA*.

⁵ Subsections 4 (2) to (3) of the *HCCA*.

⁶ Section 14 of the *HCCA*.

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'Plan of treatment' is "a plan that,

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

'Community treatment plan' is defined in the *Mental Health Act* and is a "plan that is a required part of a community treatment order."

Although the *Act* contains exceptions to the definition of "treatment,"⁷ the College advises physicians to obtain consent for all physician-patient interactions. For many of these interactions, a physician will be able to rely on implied consent.

Unless it is unreasonable to do so in the circumstances, a physician may presume that consent to treatment includes consent to variations or adjustments in the treatment, and to the continuation of the same treatment in a different setting unless there is significant change in the expected benefits, material risks or material side effects.⁸

2. Consent must be informed

Consent is not valid unless it is informed. A physician must provide a patient with information⁹ about the nature of the treatment, its expected benefits, its material risks¹⁰ and side effects, alternative courses of action and the likely consequences of not having the treatment. A physician should not assume that a patient has sufficient background or may not be interested in the information. Without full information, the patient does not have sufficient background to make informed health care decisions and consent may not be valid.

If the patient requests additional information, he or she must receive a response.

3. Consent must be voluntary

Consent cannot be given under duress. The patient must be acting for him or herself. If a physician believes otherwise, they should ensure that there has been no coercion.

⁷ The following are not considered to be "treatment": a capacity assessment, health history-taking, the assessment or examination of a patient to determine the general nature of his or her condition, communication of an assessment or diagnosis, a treatment that in the circumstances poses little or no risk of harm to the person, and admission to a hospital.

⁸ Section 12 of the *HCCA*.

⁹ Clause 11(2) (a) of the *HCCA*. The information provided to a patient must be information that a reasonable person in the same circumstances would require in order to make a decision about the treatment.

¹⁰ Whether a particular risk is material is a matter of fact. Similarly, whether the disclosure made satisfied the test of materiality is a matter of fact. The general range is from a high risk of a mild effect to a remote risk of a serious consequence. Courts have related what is material to the need for information of a reasonable or prudent person in the patient's circumstances.



4. Consent must not be obtained through fraud or misrepresentation

In conveying the information about the treatment to a patient, a physician must be frank and honest.

Evidence of Consent

Although the *Act* states that consent to treatment may be express or implied,¹¹ physicians are strongly advised to obtain express consent from the patient.

Physicians should be aware that the critical element of the consent process is the information given to the patient by the physician. Signed consent forms are simply documentary confirmation that the consent process has been followed, and the patient has agreed to the proposed treatment. Physicians are advised to note in the patient's record that consent has been obtained by noting what went into the decision-making process. Likewise, physicians should note in the patient's medical record if the patient has refused consent and the discussion that took place.

Incapable Patients

If the physician determines that a patient is incapable of consenting to a treatment, the physician must identify and obtain consent from an appropriate substitute decision-maker.

The *HCCA* sets out the following hierarchy of individuals/agencies who may give or refuse consent:¹²

1. Guardian¹³
2. Attorney for personal care
3. Representative appointed by Consent and Capacity Board
4. Spouse or partner¹⁴
5. Child or parent or individual/agency entitled to give or refuse consent instead of a parent (this does not include a parent who has only a right of access)
6. Parent with right of access only
7. Brother or sister
8. Any other relative (related by blood, marriage or adoption¹⁵)
9. Public Guardian and Trustee

¹¹ Subsection 11 (4) of the *HCCA*. Express consent is directly given, either orally or in writing. It is positive, direct, unequivocal consent, requiring no inference or implication to supply its meaning. Implied consent is consent that occurs when surrounding circumstances are such that a reasonable person believes that consent had been given, although no direct, express or explicit words of agreement had been uttered.

¹² Subsection 20 (1) of the *HCCA*.

¹³ A guardian, attorney for personal care, or representative appointed by the Consent and Capacity Board can only act as a substitute decision-maker if he or she has been given the authority to give or refuse consent to the treatment.

¹⁴ Spouse and partner are defined in subsections 20 (7) to (9) of the *HCCA*.

¹⁵ Subsection 20 (10) of the *HCCA*.

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The highest-ranking person on this list, if available, capable and willing, is the substitute decision-maker for the incapable person.¹⁶ If there is disagreement between persons described in the same paragraph, which cannot be resolved, then the Public Guardian and Trustee may be called upon to make the decision.¹⁷

A physician must provide the substitute decision-maker with the information that would otherwise have been given to the patient to enable him or her to make an informed decision as to consent.¹⁸

The substitute decision-maker must make a decision which complies with the most recent wish expressed by the person, while capable, if the following criteria are met: the person was at least 16-years-old at the time; the wish applies to the circumstances; and it is not impossible to comply with the wish.¹⁹ In other words, the substitute decision-maker must reflect on what the patient, if capable, would have wanted. At times, this decision will be extremely difficult and the physician may be able to help the substitute decision-maker.

In the event the substitute decision-maker does not know of any wish that meets these criteria, he or she must act in the incapable person's best interests. A number of factors must be considered, including the following: any values and beliefs the incapable person held while capable; any wishes the incapable person expressed that are not binding according to the above criteria; and the nature and likely effects of both providing and withholding the proposed treatment.²⁰

A physician must consider whether the substitute decision-maker is complying with the principles set out in the *HCCA*. If a physician is of the view that the substitute decision-maker is not acting in accordance with the *HCCA*, he or she can call the Office of the Public Guardian and Trustee.

Even when there is a substitute decision-maker, a physician must still involve the patient. The College advises the physician to take the following steps:

1. Tell the incapable patient that a substitute decision-maker will assist the patient in understanding the proposed treatment and will be responsible for making the final decision.
2. Involve the incapable patient, to the extent possible, in discussions with the substitute decision-maker.
3. If the patient disagrees with the need for a substitute decision-maker, or disagrees with the involvement of the present substitute, the physician must advise the patient of his or her options. These include finding another substitute of the same or more senior



¹⁶ Subsection 20 (2) of the *HCCA*. The substitute decision-maker must also be at least 16-years-old, unless he or she is the incapable person's parent and is not prohibited by Court Order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf.

¹⁷ Subsection 20 (6) of the *HCCA*.

¹⁸ Subsection 22 (1) of the *HCCA*.

¹⁹ Subsection 21 (1) of the *HCCA*.

²⁰ Subsection 21 (2) of the *HCCA*.

rank, and/or applying to the Consent and Capacity Board for a review of the finding of incapacity.²¹

4. Reasonably assist the patient if he or she expresses a wish to exercise the options outlined above in paragraph 3.

B. EMERGENCY SITUATIONS

If possible, a physician must obtain consent from a patient before providing treatment even in an emergency situation.

The *Act* states “there is an emergency if the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm.”²²

Emergency treatment without consent: Capable person

A treatment may be given without consent to an apparently capable person in an emergency, if, in the opinion of the physician:

- it is not possible to communicate the relevant information to the patient because of a language barrier or because the person has a disability that prevents the communication from taking place;
- steps have been taken to find a means of communicating but no such means has been found;
- the delay required to finding a means to communicate will prolong the patient’s suffering or will put the patient at risk of sustaining serious bodily harm; and
- there is no reason to believe that the person does not want the treatment.²³

It is critical that the physician document his or her actions in the patient’s chart. In fact, the legislation requires this.²⁴

Emergency treatment without consent: Incapable person

A treatment may be given without consent to an incapable person, if, in the opinion of a physician, there is an emergency and the delay required to obtain a consent or refusal on the person’s behalf will prolong the person’s suffering or will put the person at risk of sustaining serious bodily harm.²⁵

²¹ If the physician is informed that there will be an application to the Consent and Capacity Board (the “Board”) for a review with respect to his or her patient, the physician must ensure that treatment is not given:

- a) until 48 hours after the physician was first informed of the intent to apply to the Board without an application being made,
- b) until the application to the Board has been withdrawn,
- c) until the Board makes its decision, if none of the parties informs the physician that they intend to appeal the Board’s decision, or
- d) if a party to the application before the Board informs the physician that he or she intends to appeal the Board’s decision, until the period for commencing an appeal has elapsed with no appeal having been started, or until the appeal of the Board’s decision has been resolved. Section 18 of the *HCCA*.

²² Subsection 25 (1) of the *HCCA*.

²³ Subsection 25 (3) of the *HCCA*.

²⁴ Subsection 25 (5) of the *HCCA*.

²⁵ Subsection 25 (2) of the *HCCA*.

C. PROFESSIONAL MISCONDUCT

Under the regulations to the *Medicine Act*, certain activities can give rise to allegations of professional misconduct. Related to this policy, the following is an act of professional misconduct:

- Performing a professional service for which consent is required by law without consent.²⁶

²⁶ Ontario Regulation 856/93, as amended (made under the *Medicine Act, 1991*), paragraph 9 of subsection 1 (1).



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