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Southlake Regional Health Centre recognizes the rights, both legal and ethical, of all individuals to full and informed participation in the determination of their treatment planning. Informed and valid consent must be obtained prior to the initiation of treatment. The term 'consent' will henceforth in this document mean informed and valid consent. Consent can be obtained variably as implied or verbal or written in keeping with the nature and context of the proposed treatment. Consent is an ongoing process - it must be reviewed regularly and may be withdrawn by the patient/Substitute Decision Maker (SDM) at any time.

DEFINITIONS:

Refer to [Appendix](#) for definitions of:

- Best interests
- Capacity, including designated capacity assessor and capacity assessment
- Consent (informed, valid and hierarchy of SDMs who may give or refuse consent)
- Course of treatment
- Designated Capacity Assessor
- Plan of treatment
- Power of Attorney for Personal Care
- Public Guardian and Trustee
- Spouse
- Treatment, including plan or course of treatment

1.0. OBTAIN CONSENT

Consent may be **implied, verbal or written**. In deciding whether to seek written consent, consider the risks associated with the [treatment](#), its invasiveness, the associated degree of discomfort or side effects, whether it is urgent or elective, concerns about the patient or SDM's attitude (do they appear uncertain or find it difficult to make a decision), alternatives or consequences of not having the recommended treatment carried out. The greater the risk, invasiveness, associated discomfort/side effects, the more likely that a written consent should be obtained. Signed *verification of the consent discussion* by the patient/SDM is always required for surgical procedures and high risk procedures.

The proposer of treatment must consider and address language and/or communication issues that may impede a patient's ability to give valid consent. The proposer of treatment must take reasonable steps so as to be relatively satisfied that the patient **does understand** the information being provided. What amounts to "reasonable steps" will very much depend on the individual facts and circumstances of the particular situation. By engaging in personal dialogue with the patient, the proposer of treatment will be placed in the best possible position to be reasonably comfortable the patient understands the consent explanation.

One health care professional can propose a plan or course of treatment and obtain consent to the plan on behalf of all the health care professionals involved in the plan. If a different health professional will carry out the treatment, he/she must ensure that the patient has given consent. The **proposer of treatment** can use the *Consent to Treatment* form (#SL1271A) to document the consent discussion. Note that the Eye Institute will use the Consent form *Consent to Treatment - Eye Institute* (#SL1271D) and consent for [blood transfusion](#) is documented using form SL1271B

Consent from a Substitute Decision Maker may be requested by telephone. The proposer of treatment must take all reasonable measures to ensure that one is speaking to the correct person. The telephone consent section on the *Consent to Treatment* form is signed by the proposer of treatment. A second health care professional, registered nurse etc, who witnessed the telephone consent discussion will sign the form when they have confirmed with the person on the phone that they spoke to the proposer of treatment and consented to the treatment.

Consent to a plan or course of treatment shall include an overview of the problem(s) to be addressed needs to be given, along with a description of the proposed interventions, and the role of the other health professionals involved.

Capacity can be determined and consent obtained by one health professional on behalf of all those involved as long as each health professional has already provided the necessary information to the patient or SDM about the parts of the treatment for which he/she is responsible and has the knowledge, and has answered any questions.

As long as the risks and benefits of the treatment do not change significantly, consent given to a treatment may be presumed to include:

- Variations and adjustments in the treatment;
- Treatment that is necessary and ancillary to the primary treatment; and
- The continuation of treatment in a different setting.

A new consent is required if:

- There is a material change in the patient's condition after the consent was given
- Medical knowledge about the patient's condition or treatment available has materially changed
- If there has been a change in the patient's/SDM's consent to a portion of the treatment proposed

The patient or SDM has the right to refuse treatment and/or to withdraw consent at any time, in writing or verbally.

There is no minimum age for a patient to give consent in Ontario. An individual's capacity determines if they are able to provide consent. Age does factor into the consent process in two ways:

- A person acting as a SDM must be 16 years of age, unless they are the parent of an incapable person for whom they are making decisions;
- Where the previously expressed capable wishes of a *now incapable person* are being used to guide their treatment decisions, those wishes must have been expressed when the individual was 16 years of age or older, as per consent law in Ontario.

The Paediatric Population

There is no minimum age for a patient to give consent in Ontario. The determining factor in a child's ability to provide or refuse consent is whether the young person's physical, mental and emotional development allows for a full appreciation of the nature and consequences of the proposed treatment or lack of treatment.

Decisions for children and adolescents should be made jointly by members of the health care team, the child or adolescent's parents/SDMs, and sometimes the child or adolescent. Children and adolescents should be involved in decision-making to an increasing degree as they develop, until they are capable of making their own decisions about treatment. Information is to be disclosed at a level in which the child or adolescent is able to understand and at an age appropriate level. Respect for parental wishes and values is important, and the needs and interests of the child or adolescent should prevail.

In some situations, conflicts may arise if the values and beliefs of the parents differ from those of the patient or the health care team. If the proposer of treatment and health care team believe that these decisions are inconsistent with the child or adolescent's best interests then consultation with the hospital's Ethicist and/or the Children's Aid Society (as per the [Child Abuse-Mandatory Reporting to the Children's Aid Society](#) policy and procedure) is required.

2.0 DETERMINE CAPACITY

No treatment can be given unless the health professional who proposes treatment is of the opinion that:

- The patient is capable with respect to that treatment; and
- Consent has been given by the capable patient, or if he/she is incapable, by his/her SDM, in accordance with the legislation.

A patient is presumed to be [capable](#) unless significant evidence is present to question his/her ability to understand and appreciate the proposed treatment. If the health professional finds the patient capable, the patient's directions with respect to the treatment are carried out.

If the patient is deemed to be incapable, it is prudent that the healthcare practitioner who is proposing treatment document in the health record the basis for the conclusion that the patient is incapable of consenting. This should include reference to the elements of the applicable test for capacity, the dates and results of any capacity assessments performed, and any second opinions sought. (CMPA 2016).

If the patient is found to be incapable and there is no emergency, the health professional who proposed the treatment must:

- Inform the patient of this finding;
- Explain that a SDM will make the decision;
- Explain to the patient his/her right to appeal the finding, or the involvement of the person named as SDM, to the Consent and Capacity Board;
- Assist the patient to approach the Consent and Capacity Board if necessary, and if requested to do so by the patient.

Exception: A patient does not have the right of appeal if he/she has a court appointed guardian who has the authority to give or refuse consent, or an attorney for personal care whose authority specifically waives the patient's right to appeal to the Consent and Capacity Board. If the patient states the intention to apply to the Consent and Capacity Board for a review of the finding, or for the appointment of someone with Power of Attorney, nonemergency treatment must be delayed until the Consent and Capacity Board has made a ruling.

The role of the Consent and Capacity Board is to provide fair, timely, effective and respectful hearings that balance legal and medical considerations while protecting individual rights and ensuring the safety of the community.

If an incapable patient regains capacity with respect to the treatment, his/her decision to give or refuse consent to the continuation of the treatment governs, and the SDM is informed of this change. (This does not apply if there is a court appointed guardian.)

3.0 SUBSTITUTE DECISION MAKER - Identification and Role

A SDM is a person legally authorized to give or refuse consent for treatment on behalf of someone who is incapable with respect to the treatment being proposed.

The following is the **ranked** order of SDMs who may give or refuse consent:

1. Court appointed "guardian of the person"
2. Power of Attorney for Personal Care
3. Representative appointed by the Consent and Capacity Board
4. Spouse or partner
5. Child or parent (parents with custody are ranked equally);
6. Parent with right of access only;
7. Brother or sister;
8. Any other relative (defined by law as related by blood, marriage or adoption);
9. Public Guardian and Trustee (call 416-314-2755 for regional contact or Ontario office at 1-800-366-0335, option 3).

The proposer of treatment will review the ranked order of SDMs and select the highest ranked person in the list. In order for the selected SDM to give or refuse consent he/she must meet all of the following criteria:

- Capable of giving or refusing consent with respect to the specific treatment;
- At least 16 years of age, unless is the parent of an incapable person;
- Not prevented by a court order or separation agreement from giving consent;
- Available, and
- Willing to assume the responsibility of giving or refusing consent

If there are reasonable grounds to believe that a SDM does not meet all of the criteria above, the proposer of treatment must seek consent from the next ranked SDM from the list that meets the criteria.

If the incapable patient's SDMs are identified as one or more equally ranked persons, i.e. child or parent of the incapable patient, two or more siblings, and they disagree about whether to give or refuse consent, the Public Guardian and Trustee shall make the decision in their stead.

A SDM is obligated to act in accordance with the incapable patient's last known wishes, or if unknown, in the patient's best interests, and may not override a decision made by the patient, expressed verbally or in writing, when capable. If there is a concern within the health care team that the SDM is not acting in accordance with this legislation, the proposer of treatment can apply to the Consent and Capacity Board for review. Consultation with the Ethicist and/or social Work may be appropriate for support in this process (also refer to the [Elder Abuse-Reporting of in Acute Care](#) policy).

4.0 EMERGENCY CONSENT

In the case of an emergency (i.e., a delay would prolong the patient's suffering or would put him/her at risk of sustaining serious bodily harm) proceeding with emergency treatment without consent can occur if:

- The patient is incapable **and** the substitute decision maker cannot be reached
- The patient appears capable but the communication required to obtain consent cannot occur because of a language barrier or disability and no reasonable way has been found for communication to take place, **and** if the treatment does not go against advance directives, instructions, or wishes already expressed.

In the case of emergency treatment without consent, efforts must continue to be made to locate a SDM and overcome communication barriers. The Emergency Treatment Without Consent section on the *Consent to Treatment* form is signed by the proposer of treatment. Emergency treatment without consent shall only continue until the patient regains capacity or a substitute decision maker is found. The capable patient's/SDM's wishes regarding continuation of treatment will then apply.

5.0 REFUSAL OF CONSENT AND DOCUMENTATION OF REFUSAL

A capable patient may refuse a treatment on any grounds, even when it is clear that the treatment is necessary to preserve his/her life or health. The proposer of treatment must respect the wishes of the patient and the treatment/procedure will not be carried out even if failure to do so may result in the patient's death.

If a patient refuses a treatment/procedure, the proposer of treatment shall explain the risks and clinical consequences of the refusal to the patient without creating the perception of coercion. The proposer of treatment must document the refusal in the patient's health care record. This explanation may be witnessed by a second health practitioner and documented in the health record.

The proposer of treatment may consider referring to social work to explore values and beliefs guiding decisions and assist in negotiating a plan of care that is aligned with what matters to the patient/SDM.

6.0 DOCUMENTATION OF CONSENT

If the proposer of treatment has a consent discussion with the patient/SDM while the patient/SDM is neither a registered outpatient nor an admitted inpatient of Southlake, the proposer of treatment will document that discussion in their office records.

If the proposer of treatment has a consent discussion with a patient/SDM while the patient is either a registered outpatient or an admitted inpatient of Southlake, the proposer of treatment must document that discussion in Southlake's patient health care record. The proposer of treatment can choose to use the *Proposer of Treatment* section of Southlake's Consent to Treatment form to document the consent process in the patient's health care record .

All signed *Consent to Treatment* forms will be filed in the *Consent* section of the patient's health record.

7.0 VERIFICATION OF A CONSENT DISCUSSION:

Signed verification, by the patient/SDM, that there has been a consent discussion between the patient/SDM and the proposer of treatment is always required for surgical and high risk procedures.

A member of the health care team (HCT) will provide the patient/SDM with the *Verification of Consent Discussion* section of the *Consent to Treatment* form for review and consideration of signing. The healthcare provider (HCP) will only fill in the name of the 'operation(s), test(s), treatments(s)' in the blank space provided on the Consent to Treatment form when the information is known and verifiable.

The HCT member presenting the form to the patient/SDM is not getting consent or witnessing consent. The HCT member is providing the *Verification of Discussion for Consent to Treatment* form to the patient/SDM. By signing, they are verifying that they have had a full consent discussion with the proposer of treatment.

If the HCT member has any concerns about the patient/SDM's understanding of the treatment being consented for, they must notify the proposer of treatment in a timely manner. The HCT member should not enter into a consent discussion with the patient/SDM.

8.0 POWERS OF ATTORNEY

If Power of Attorney for Personal Care or guardianship documents are provided, copies must be made and placed in the Advanced Directives section of the health record.

Power of Attorney for Personal Care:

If there is **no** known Power of Attorney for Personal Care, and the patient is capable of

understanding and appreciating a decision around assigning one and wants to complete the documents to assign one, a team member may refer to the social worker who can offer basic education and information regarding Power of Attorney. (This may include providing an information kit prepared by the Ontario government, assistance in reading the information, and advice to seek legal counsel.) As a note, the healthcare provider is not a signing officer and cannot act as a witness to these documents as per policy [Witnessing Legal Documents](#).

APPENDIX – DEFINITIONS

Best interests: the patient's known values, beliefs, and wishes; whether the decision is likely to improve the patient's life or prevent or reduce the patient's quality of life from deteriorating; whether the benefits to the patient outweigh the risks; and whether no treatment or a less restrictive or intrusive treatment would be as beneficial as that being proposed. Note: A health professional who believes that a substitute decision maker is not following the best interests or wishes of the incapable person should document his/her concerns, discuss the matter with the team, and if necessary bring it to the Consent and Capacity Board.

Capacity: ability to understand the information that is relevant to making a decision concerning a particular treatment (or in the case of Power of Attorney for Property, to make a decision considering property), and to appreciate the reasonably foreseeable consequences of a decision or lack of decision. Capacity relates to a specific action proposed, i.e., a person may be capable of consenting to a specific treatment, but not to another, and may be capable at some times, and not at others.

Capacity Assessment: The formal assessment of a patient's mental capacity to make decisions about property or personal care under the *Substitute Decisions Act* conducted by a designated Capacity Assessor, e.g., discharge planning, except Long Term Care, assignment of Power of Attorney for Personal Care and Power of Attorney for Property, management of finances.

Consent - the following elements are required for consent to be informed and valid:

- Person is mentally capable to consent;
- Consent relates specifically to the treatment proposed;
- Consent is informed, i.e., the individual has received all information that a reasonable person in the same circumstances would require, and has had the opportunity to ask questions and to receive understandable answers about the nature, purpose, expected benefits, significant risks and side effects, reasonable alternative courses of action, and likely consequences of not proceeding, communicated with consideration to his/her education, age, language, culture, and special needs;
- Consent is not obtained through misrepresentation or fraud (i.e., pertinent details were not withheld, and the information was not presented in a misleading way);
- Consent was given voluntarily.

Course of treatment: means a series or sequence of similar treatments administered to a person over a period of time for a particular health problem

Designated Capacity Assessor: a person who is qualified and designated by the legislation to determine capacity. In some circumstances, the *Substitute Decisions Act* gives capacity assessors the exclusive authority to make such determinations. Power of Attorney for Personal Care: a patient is capable of designating or revoking a Power of Attorney for Personal Care if he/she has the ability to understand whether the proposed individual has a genuine concern for his/her welfare, and appreciates that this individual may make decisions on his/her behalf if the patient is found not capable with respect to a specific care decision at the time of the proposed treatment. Provincial legislation allows a capable individual to designate a Power of Attorney for Personal Care to make decisions regarding some or all the 6 areas of personal care, health care, nutrition, shelter, clothing, hygiene, safety, as determined by the instructions given in the Power of Attorney document.

If the Power of Attorney names 2 or more persons as attorney, they act jointly, unless the Power

of Attorney document provides otherwise. If two or more Powers of Attorney or two or more persons of equal rank claim authority and disagree regarding consent, or if no one meets the requirements of substitute decision maker following reasonable inquiry, the decision must be referred to the Public Guardian and Trustee.

Plan of treatment means a plan that:

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

Public Guardian and Trustee: is responsible for making decisions on behalf of incapable individuals when there is no one who is available, capable, or willing to act as substitute decision maker/ Power of Attorney. The Public Guardian is the substitute decision maker of last resort. A formal capacity assessment is required to designate a Public Guardian and Trustee. Role in Care Decisions: When no Power of Attorney for Personal Care has been assigned, the Public Guardian and Trustee may be consulted for treatment decisions, and for consent for admission to long term care.

Spouse: a person of the opposite or same sex to whom the person is married, or with whom the person is living in a conjugal relationship outside marriage if the two persons have either cohabited for at least one year, or are together the parents of a child, or have together entered into a cohabitation agreement under the *Family Law Act*. **Partners:** two persons who have lived together for at least one year and have a close personal relationship that is of primary importance in both persons' lives.

Treatment: anything done for a therapeutic, preventive, palliative, diagnostic, cosmetic, or other health-related purpose, including a plan or course of treatment. The following are **not considered as treatment** and therefore do not require consent:

- Assessment of capacity to make a decision regarding a proposed treatment;
- Assessment or examination to determine the general nature of the person's condition;
- Taking of a health history;
- Communication of an assessment or diagnosis;
- Personal assistance services i.e., assistance with or supervision of hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, positioning, or any other routine activities of living;
- Admission to a hospital or other facility;
- Treatment that in the circumstances poses little or no risk of harm to the person;
- Use of physical restraints (covered under other legislation).

Plan or course of treatment:

- Developed by one or more health professionals;
- Deals with one or more of the health problems that a person has or is likely to have in the future given his/her current health condition;
- Provides for the administration of various treatments or courses of treatment over a period of time, for a particular health problem;
- May provide for the withholding or withdrawal of treatment in light of the person's current health condition.

APPLICABLE LEGISLATION

- Health Care Consent Act, 1996 http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96h02_e.htm
- Substitute Decisions Act - http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_92s30_e.htm

- Consent and Capacity Board - <http://www.ccboard.on.ca/>
- Public Guardian and Trustee - <http://www.attorneygeneral.ius.gov.on.ca/english/family/pgt/>

References:

- College of Physicians and Surgeons of Ontario Policy Statement (2015) <http://www.cpso.on.ca/policies-publications/policy/consent-to-medical-treatment>
- College of Nurses of Ontario (2009) Practice Guideline: Consent http://www.cno.org/Global/docs/policy/41020_consent.pdf
- Health Care Consent Act (1996) http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96h02_e.htm
- Mental Health Act (1990) http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90m07_e.htm
- Canadian Medical Protective Association
- Content adapted from Bruyere Continuing Care Consent policy
- Content adapted from Alberta Health Services Consent policy
- Canadian Paediatric Society Position Statement *Treatment decisions regarding infants, children and adolescents*. Feb 1, 2016. <https://www.cps.ca/en/documents/position/treatment-decisions>
- The Hospital for Sick Children Consent to Treatment Policy June 2017.

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