Pictou County health Authority

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SUBJECT: CONSENT FOR TREATMENT

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For the purposes of this document, that the terms "patient" and "he/she" are being used to reflect the individuals who access services within the Pictou County Health Authority (PCHA). The reader is advised to substitute the term patient with client or resident depending upon the services accessed and to utilize he or she as appropriate.

In Nova Scotia, there is no legislated age of consent, except in the context of the Human Tissue Gift Act (RSNS, 1989, C215).

This policy provides general guidelines regarding the process of obtaining consent but professional judgment will also be required.

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Original:
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DEFINITIONS:

Capacity: Capacity to consent is two fold:
Is mature enough to understand the nature, risks and benefits of the treatment decision and understands that the explanation applies to him/her or the individual he/she is consenting for.

Child: A person under 16 years of age unless the context otherwise requires.

Common-law partner:
An individual who has cohabitated with the patient in a conjugal relationship for a period of at least two years.

Minor:
An individual under the age of majority for Nova Scotia which is 19.

Next-of-kin:
The person shown on the records of the facility.

Physician/Treating Health Care Professional:
The person proposing the treatment and is in the best position to explain the risks/benefits/alternatives to the patient, and answer the questions of the patient.

Substitute Decision Maker:
A person appointed under the Adult Guardianship Act as a substitute decision maker.

Test or Treatment:
Includes any investigation, test, procedure, operation, and/or therapy that may be carried out in providing care to a patient.

POLICY:

The patient has the right to be informed of the nature and the purpose of the recommended test or treatment, the anticipated risks and benefits, alternate forms of care and the consequences of declining either the recommended or alternate forms of tests and treatments. Physicians/treating health care professionals have the responsibility of ensuring that this information is provided to the patient and that the patient understands this information.

The information given must be based on what a reasonable person would want to know. The Supreme Court of Canada has stated that a risk is material or probable in direct relation to its incidence and the severity of the consequences should the risk materialize (*Reibl v. Hughes*, [1980] 2 S.C.R. 880). Consent involves not only disclosing pertinent information but also fully responding to the patient's questions.

Consent is a process involving the interaction of physician/treating health care professional and patient wherein the physician/treating health care professional endeavors to communicate the nature of a planned procedure along with the risks, benefits, and alternatives. The patient endeavors to comprehend all this and determine whether he or she is in agreement with the planned procedure. Physicians/Health Care Professionals shall make timed and dated notations in the patient's clinical record indicating that the informed consent discussion has occurred, and summarizing its contents. The signed form, by itself, is no guarantee of consent, but is evidence that the process has taken place.

GUIDELINES

1. REASON FOR OBTAINING CONSENT

The reason is an ethical one: The patient has the right to be informed about the nature, possible effects and outcomes of any treatment proposed. Professionals have the responsibility of ensuring that this information is provided to the patient and that the patient understands the information.

2. CONSENT TO TREATMENT REQUIRED

Section 54 of the *Hospitals Act* R.S.N.S., (1989) c. 208 states that, "No person admitted to a hospital shall receive treatment unless he consents to such treatment."

2.1 Presentation at any PCHA treatment facility for provision of services or admission, constitutes implied consent for ordinary diagnostic or treatment measures.

2.2 Written consent is required for (but not limited to) the following:

- For all surgical procedures involving a general and/or regional anaesthetic;
- For all procedures that substantially impair the level of consciousness of the patient through analgesics, anesthetics, or narcotics;
- For any procedure involving an appreciable risk to the patient or of which the patient should have particular knowledge before initiation or wherein the most responsible practitioner's judgment there is sufficient risk as to make a written consent, rather than verbal consent advisable (cardioversion, lumbar puncture, bone marrow aspiration and/or biopsy).
- For any procedure(s) utilizing a laser.
- Any procedure involving the removal of/or impairment to a body part or a bodily function.
- Any procedure involving the injection of contrast media/dye.
- During care and treatment, where there is any recording on videotape, audiotape, photographic film, or digital camera, except in cases of suspected child abuse.
- Participation in any research study/clinical trial
- For immunization of infants/children where the parent/guardian is not in attendance.
- Administration or refusal of all blood and blood products.

2.3 Verbal consent is acceptable when the written consent is necessary but cannot be obtained due to exceptional circumstances that prevent the patient from signing.

2.3.1 **Verbal consent must be confirmed in writing by a second person who has heard the consent.**

3. CRITERIA FOR A VALID CONSENT

Information Provided during the consent process must be understood include the following:

a) The nature and purpose of the proposed treatment;
b) The intended benefits;
c) Probable risks or complications;
d) The consequences of foregoing all treatment; and
e) Alternatives available.

Written consent must be free of abbreviations.

To be valid, a consent must:

3.1 be voluntarily given: The patient must be in a position to choose freely between consent and non-consent without the feeling of coercion/undue influence.

3.2 be informed: - The patient must understand the nature and purpose of the procedure proposed.
- They must understand the material risks, potential benefits, and consequences of the treatment or procedure as well as the risks and consequences of not receiving the treatment or procedure and alternatives.

3.3 be given to the act performed:
- The patient must give his/her consent to the specific nature of the treatment or procedure.
- If the possibility of one or more minor modification or the possibility of additional or alternative measures is suspected, the physician/treating health care professional shall obtain consent for those modifications or measures before the procedure is performed.

3.3.1. Additional or alternative investigations, treatments or operational procedures that are **immediately necessary** may be performed.

3.4 be given by one who is legally and mentally capable of giving consent.

4. CONSENT BY TELEPHONE

4.1 In situations where the patient is unable to consent and treatment is required promptly to prevent the patient's health from deteriorating or to alleviate unnecessary pain and discomfort, a telephone consent may be obtained from the patient's next of kin. The physician/treating health care professional who has placed the telephone call must determine:

a) the relationship between the patient and the person to whom the call was placed; and
b) the person's willingness to give or refuse consent to treatment on behalf of the patient.

The same requirements for informed consent exists for a telephone consent as for a written document. Therefore, if the person to whom the call was placed is willing and able to make a treatment choice for the patient, the physician/health care professional must explain the aforementioned criteria (see section 3).

4.2 The person to whom the call was placed must be given an opportunity to ask questions regarding the proposed treatment. **This call must be monitored by a second person who will act as a witness to the process – a speaker phone is suggested.**

4.3 The witness should verify the person's name and relationship to the patient when verifying consent.

4.4 Documentation is very important with a telephone consent. Notation must be made of:

a) the reason why the patient was unable to consent;
b) the name of the person placing the call;
c) the time and date of the call;
d) the number called and the name of the person to whom the call was placed;
e) the relationship between the patient and the person to whom the call was placed; and
f) the name of the person monitoring the call as the witness.

4.5 A summary of the information given and received shall be placed on the patient's health record.

5. RESPONSIBILITY FOR OBTAINING CONSENT

A physician cannot delegate the responsibility of obtaining consent to a nurse.

5.1 Obtaining consent is the responsibility of the physician/treating health care professional proposing the treatment and is in the best position to explain the risks/benefits/alternatives and answer the questions of the patient, or the substitute decision maker.

5.1.1 It is the responsibility of the physician/treating health care professional requesting the consent to determine whether or not the person consenting is capable of doing so and has been correctly informed

5.1.1.1 In all situations where the physician/health care professional feels that the consent obtained could be open to question, he/she shall document the reason for accepting the consent in the patient's health record.

5.2 Where a health professional believes that this policy has not been followed correctly, and therefore the consent obtained is not informed and/or valid, then it is his/her responsibility to bring it to the attention of the attending physician/treating health care professional. If such concerns are not satisfactorily addressed the Department Manager and/or Chief of Staff, or Director shall be informed.

6. WHO MAY GIVE CONSENT

6.1 A person with the mental capacity to understand the explanation given to him/her may give consent.

6.1.1 A person cannot be assumed incompetent to consent merely because he/she is under psychiatric treatment. A person may be mentally ill, but if his/her illness does not affect his/her decision making process with regard to consent, that person would be considered competent to consent. If mental capacity is in doubt, a second medical opinion should be obtained and documented. If still in doubt, a psychiatrist should be consulted.

6.1.2 A person who is under the influence of drugs or alcohol could possibly be considered not of sound mind and therefore not able to consent without assessment of capacity. Consent obtained from such a person could be invalid or at least open to question. The physician/treating health care professional in such a situation must be cautious. If the physician/treating health care professional decides to accept the consent from such a person, he/she must document in the patient's health record his/her reason for doing so.

Consent obtained under the above circumstances can only be obtained under extenuating circumstances. Capacity must be assessed at the time that consent is sought and the deciding factors are the ability to understand the nature, risks, and benefits of the proposed treatment. Documentation of the following is critical and shall include:

a) the circumstances surrounding obtaining consent; and
b) the assessment of capacity

Written consent shall be obtained as soon as the patient is deemed competent.

6.2 The minor can give his/her own consent, if, in the judgement of the physician/treating health care professional, the minor has the capacity. The younger the patient is, and the more significant the procedure, the greater the care shall be to evaluate capacity. This may involve obtaining a second opinion from another physician/health care professional and documentation of the second assessment.

6.3 If the patient is not capable of consenting, by reason of mental or physical disability, consent may be obtained from one of the following persons, in this order of priority:

a) legally appointed guardian (proof of documentation required)
b) a person who the patient, when competent, appointed as his/her proxy under either the Powers of Attorney Act or the Medical Consent Act (proof of documentation required)
c) spouse

d) next of kin (children 19 years of age or older, either parent, brother or sister)
e) Public Trustee (See Appendix I).

The physician/treating health care professional, when obtaining consent from a person on behalf of the patient, must use the same criteria for informed consent (see section 3. Criteria for a Valid Consent).

6.4 Consent **may not** be given by:

6.4.1 A person who lacks the capacity to consent.

6.4.2 A person who has been declared incompetent by a Court, regardless of his/her actual state of mind.

6.4.3 Any individual acting for a minor, who is not the parent or legal guardian, unless he/she has been formally appointed guardian by the Court and he/she can produce the documentation proving guardianship.

6.4.4 A spouse who is legally separated from the patient.

6.4.5 A care provider for developmentally disabled individuals or a care provider for individuals who are incompetent, unless he/she has been formally appointed guardian by the Court and he/she they can produce the documentation proving such guardianship.

6.4.6 Any other individual other than the minor for the non-therapeutic sterilization of the minor.

6.4.7 A minor or common law spouse cannot, under any circumstance, make decisions on tissue donation pursuant to the *Human Tissue Gift Act (RSNS, 1989, c.215)*

6.4.8 An individual under the influence of drugs or alcohol who has been assessed as not being capable of doing so.

7. OBTAINING CONSENT FROM BLIND, DEAF, ILLITERATE OR FOREIGN SPEAKING PATIENTS

In order to fulfill the necessary criteria for a valid consent, it is imperative that communications are made in a manner the patient can understand.

7.1 When a person consenting does not speak a language fluently enough to understand the explanation, the physician/treating health care professional must use the services of an interpreter. The interpreter shall sign a document indicating or confirming what the patient was told and that the patient confirmed or agreed to the treatment/procedure. The patient shall also have the opportunity to ask questions and have them answered. If an impartial interpreter is not available, then a family member may act as interpreter.

7.2 When the person consenting is deaf, the physician/treating health care professional must use the services of an interpreter and have the interpreter sign a statement confirming what the person was told. Alternatively, where the consent giver can read, the physician/treating health care professional can write an explanation and similarly attach the written explanation to the consent form. A notation should be made on the form or in the progress notes that the patient is blind or illiterate.

7.3 When the person consenting is blind or illiterate, the physician/treating health care professional, will give the explanation, read the consent form, and the consent giver will then sign the consent form by making his/her personal mark which shall then be witnessed.

8. WITNESSING

8.1 Any adult of sound mind may witness consent taken by a physician/treating health care professional.

8.2 In signing as a witness, the individual merely certifies that the patient or individual named on the form was the person signing it. The witness is not certifying the validity of the consent itself.

8.3 The person obtaining consent shall conclude the process by completing the consent form and having the patient's or substitute decision maker's signature witnessed.

8.4 If the patient or his or her substitute decision maker is unable to physically sign the form, then the signatures of two witnesses are required. If applicable, a notation shall be made on the consent form or in the progress notes, to indicate that the form was read to the patient and why the patient could not sign.

9. DURATION OF VALIDITY

9.1 A consent is considered valid until one of the following occurs:
- a) consent is withdrawn by the patient or substitute decision maker;
- b) the patient or substitute decision maker indicates that they do not understand;
- c) a change is made to the procedure/treatment consented to by the patient;
- d) the consent is no longer consistent with the patient's medical or physical condition;
- e) further risks become known or alternative treatment(s) become available;
- f) the treatment/procedure that has been consented to has been completed or performed; or
- g) twelve months have passed.

9.2 The physician/treating health care professional shall reconfirm that the patient has had the procedure fully explained and had an opportunity to ask questions if more than one month has passed and to document the process with a new written consent form if more than twelve months have passed.

9.3 It is the physician's/treating health care professional's responsibility to ensure that the consent has remained valid from the completion point of the consent process to the time of the surgery or procedure.

9.4 If a patient loses capacity to consent after consenting to a procedure or treatment, the consent continues to be valid. However, the consent shall be validated with the substitute decision maker.

10. EMERGENCIES

10.1 The only time a patient can be treated without consent is in a medical/legal emergency.

10.2 **All** of the following criteria are necessary to establish an emergency and must be documented:
- a) There must be a threat to the life of a patient or a danger to others.
- b) The threat must be an immediate one. If the procedure can be delayed (without endangering the life of the patient) until consent can be obtained, then it must be postponed. The fact that it may be required or that it may be more convenient to perform it at that time is not relevant.
- c) It must be impossible to obtain consent from the patient or the substitute decision maker.
- d) Refusal of consent must not have been indicated.

10.2.1 For emergency treatment of a child/minor/adult, in the absence of consent, the physician performing the procedure, and whenever possible a second physician, will complete and sign the consent form. It is strongly advised to obtain the opinion of a second physician.

10.3 In a medical/legal emergency, the physician/health care professional shall:
- a) Document the circumstances in the progress notes including the medical condition of the patient as well as all attempts made to contact the patient's substitute decision maker;
- b) Proceed with the treatment to which a reasonable, prudent individual in the patient's circumstance would be expected to consent; and

c) Obtain consent from the patient or substitute decision maker as soon as practical.

11. REFUSAL OF CONSENT/WITHDRAWAL OF CONSENT

11.1 As long as a patient has the legal competency and mental capacity, he/she has the right to refuse a proposed treatment or diagnostic procedure, except in the following circumstances:

11.1.1 The patient is suffering from certain specified communicable diseases for which treatment is mandatory under the Health Act (RNSN, 1989, c.195).

11.1.2 The patient has been forcibly confined to a facility pursuant to Hospitals Act (RSNS, 1989, C. 208) or the Criminal Code, he/she does not automatically lose his/her right to consent to treatment or refuse treatment. However, under that Act, an assessment must be done by a psychiatrist to determine the patient's capacity to consent. If a psychiatrist determines that the patient is capable of consenting it also follows that the patient is capable to of refusing treatment.

11.2 A substitute decision maker cannot refuse consent on behalf of a competent patient.

11.3 To initiate treatment without consent is considered BATTERY. If a competent patient or substitute decision maker refuses treatment, it is important to explain the clinical consequences to him/her and to document the discussion in the progress notes. The patient or substitute decision maker will then sign the "Release of Responsibility for Discharge/Treatment" form.

11.4 In the case of an adult who arrives at the hospital in an emergency condition, who is incapable of giving consent, and who carries a written statement refusing treatment, the physician/health care professional shall consider the written statement as a refusal of treatment. It is not the responsibility of the physician/health care professional or of the hospital staff to search for such written statements.

11.5 When consent for medical treatment of a minor is required from a parent or guardian and is refused or unobtainable, anyone can apply to the Supreme Court of Nova Scotia for an order dispensing with the consent. The Department of Family & Children's Services must be contacted in order to start this process. (Children & Family Services Act, RSNS, 2002, c.5). **Children & Family Services Act is applicable to a person under 16 years of age.**

11.5.1 The judge may dispense with the consent only when he/she is satisfied that withholding the medical treatment would endanger the life or health of the minor.

11.5.2 In the case of child abuse or when a child is in the custody of a parent or guardian who refused to consent to necessary diagnostic or treatment measures, the case will be referred directly to the Department of Family & Children's Services for appropriate case intervention. (Children & Family Services Act, RSNS, 2002, c.5).

11.6 The principles of consent also encompass the patient's right to withdraw consent. It is important that the patient and/or substitute decision maker understand the consequences of withdrawing consent. This shall be made clear in any documentation provided to them and in any discussions with them. The withdrawal of consent shall be noted on the progress notes.

12. ADVANCED DIRECTIVES (i.e., Living Will, Advanced Treatment Directive)

Advanced directives are not legally binding in Nova Scotia. However, advanced directives can be of value to health care providers because they provide an advance expression of a patient's health care preferences. They also may remove some of the burden from family members who would be expected to be the substitute decision maker in the event that the patient became incapacitated.

13. RELEASE OF INFORMATION

For release of information from the Health Records Department, see policy "Release of Information".

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MEMORANDUM

This Memorandum is meant to provide you with an overview of the process involved in applying to the Public Trustee for consent to medical treatment. Please find attached for your records a copy of Forms "A" through "F" and Schedule "H" referred to in the body of the Memorandum. Please keep these documents on file for future use.

The Public Trustee has the authority to consent to medical treatment on behalf of individuals who lack the capacity to consent on their own behalf, pursuant to sections 54 and 55 of the *Hospitals Act*. These sections read as follows:

Consent to hospital treatment

> **54** (1) No person admitted to a hospital shall receive treatment unless he consents to such treatment.
>
> (2) If a person in a hospital is found by declaration of capacity to be incapable of consenting to treatment then that person may be treated either upon obtaining the consent of the guardian of that person, if he has one, or if he has not a guardian upon containing the consent of his spouse or common law partner, if the spouse or common law partner is cohabiting with the person in a conjugal relationship, or next of kin and where the spouse or common-law partner or next of kin is not available or consent is unable to be obtained upon obtaining the consent of the Public Trustee.
>
> **55** The examination of a person in a hospital by psychiatrist to determine whether or not that person is competent to administer his estate or capable of consenting to treatment may be performed at any time as the need arises, and notwithstanding this, such an examination in a facility shall be performed
>
> (1) at least once every three months for the first year during which the person is a patient;
> (2) at least once every twelve months thereafter.

This means that the Public Trustee's authority to consent to medical treatment arises when a patient:

(a) is in a hospital; and
(b) found by declaration of capacity to be incapable of consenting to treatment; and
(c) does not have a guardian, or spouse or next of kin available to consent or such consent is unable to be obtained; and
(d) the proposed treatment is necessary for the benefit of the patient.

The legislation precludes the Public Trustee from consenting to treatment of individuals in a physicians office, nursing home, or small options home etc. and appears to make it mandatory to admit all such patients in the hospital for medical and/or surgical procedures.

A typical application to the Public Trustee for a consent to treat order may proceed as follows:

1. The physician in a long term care facility, believing that the patient requires treatment, will prepare and deliver to the administrator of the long term care facility a written diagnoses and treatment recommendation in affidavit form (see Form "A" attached). It will not be necessary to prepare Form "A" if Forms "D" and "E" (see attached) are prepared by physicians, setting out the diagnosis, treatment plan and the need for treatment.

2. The administrator of the long term care facility and a social worker who has knowledge of the patients social background, if available, will each make an affidavit describing why they believe that patient has no guardian, spouse, or next of kin available to consent or why such consent is not able to be obtained (see Forms "B" and "C" attached).

3. The physician in a long term care facility, the administrator of the long term care facility and/or the social worker will arrange for the patients admission to a hospital.

4. Forms "A", "B" and "C" should be delivered to the hospital administrator prior to the patient being admitted or upon admission.

5. After the patient is admitted at the hospital they should be seen immediately by a psychiatrist, who will make, or decline to make and file with the hospital administrator, a declaration of capacity as per Schedule "H", Regulation 10, *Nova Scotia Hospitals Act* (see attached).

6. The patient will then be examined by staff physicians who will make a diagnosis and recommend a treatment plan. After assessment and

consultation, Form "D" should be prepared by the qualified physician who will be carrying out the medical treatment. Attached to Form "D" should be the medical report, which includes the diagnosis and recommended medical or surgical procedure. It should always be remembered that the Public Trustee is not a physician, so, the report should be written in a manner and in terminology understandable to a non-medical person, a patient or a family member of the patient. (The above mentioned medical report is referred to as an exhibit in paragraph 6 of Form "D".) Form "E" should be completed by another physician who participated in the diagnosis and concurs with the recommendation for treatment.

7. If the patient is not expected to require a hospital bed for one full day or more (e.g. they are being admitted for day surgery), he or she should be taken to the hospital were he or she will be treated, at an earlier date, not more then three months in advance of the date of the scheduled procedure, to allow the physicians to do the examinations necessary to prepare the treatment plan and the Declaration of Capacity (Schedule "H").

8. As soon as the medical decisions and affidavits have been made, the hospital administrator, or a member of the hospitals social work department, should make a formal application to the Public Trustee for consent to treatment (see Form "F"). It is recommended that you provide the Public Trustee office with as much advance notice of the application as possible.

9. Once the Public Trustee receives all the required documentation, and it is established that the individual is in the hospital, has been found to be incapable of consenting to treatment, does not have a guardian, or spouse or next of kin available to consent or such consent is unable to be obtained and that the proposed treatment is for the benefit is the individual, she will grant her consent to treat and immediately send notice to the hospital where the medical treatment is being carried out.

Generally, Forms "B" through "F" (Form "A" is often not required) are sent to the Public Trustee well in advance of the individuals admission to the hospital, thereby providing the Public Trustee with notice that a consent to treat is required and when it will be required.

It is not uncommon for the Public Trustee to receive consent to treat applications from administrators of long term care facilities, social workers at long term care facilities, or from the administrators or members of the social work department from the treating hospital, in situations where diagnostic tests and procedures cannot be carried out on a person without the administration of a general anaesthetic. In such a case, the application to the Public Trustee will be an application for consent to the administration of a general or specific diagnostic procedure (under general anaesthetic if recommended) and not necessarily for consent to specific remedial treatment.

It also must be understood that the consent to medical treatment or specific diagnostic procedure granted by the Public Trustee will cover only the treatment plan set out in the application. This means that if one month later the same individual requires further medical treatment, an additional application will have to be made to the Public Trustee.

Please see Department of Justice website at http://www.gov.ns.ca/just/pubtrustee.htm to obtain copies of the consent forms.