Guysborough Antigonish Strait Health Authority
Working Together for a Healthy Community

ADMINISTRATIVE
Community and Public Relations

TITLE: Consent to Treatment	**NUMBER: 3-11**
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Applies to: All GASHA Employees, Patients, Families and Users	

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POLICY

The Guysborough Antigonish Strait Area Health Authority supports the principle that every human being of sound mind has the right to determine what will be done with his/her own body. All actions that involve intentional interference with the person or any significant risk to the person fall under this principle. Such actions include, but are not limited to all surgery, some drug treatments and many diagnostic investigations.

Consent is obtained when a patient, or someone acting on behalf of the patient (the patient's substitute decision maker), agrees to proceed after being adequately informed of the proposed intervention. The consent process is ongoing. It creates a relationship based on effective communication and trust between the patient and the treating health professional. The consent

process will be initiated and completed by the treating health professional. This person is in the best position to explain risks/benefits alternatives.

The GASHA Health Authority recognizes that the mere signing of a consent form by a patient does not in itself provide conclusive proof that the patient in fact consented. Rather, the consent form in the health record acts as a record of the fact that the consent process took place. What matters in assessing whether the patient gave a valid informed consent is the information and understanding that the patient actually had regarding the procedure.

This policy is divided into two parts. The first part discusses the general rules of consent to treatment, and the second part discusses more specific situations. Please note that the general rules of consent to treatment must also be applied to the specific situations.

Consent to Treatment Required

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

While consent may be either oral or written, it is the policy of GASHA to obtain written evidence that the consent process occurred from all patients prior to administration of any invasive/high risk treatment.

It is the policy of facilities governed by the GASHA, to obtain written consent for the following:

1. All procedures requiring general anaesthetic.

2. All other procedures which, in the opinion of the treating health professional, require consent, such as the administration of chemotherapy, blood or blood products and invasive diagnostic testing.

Criteria for a Valid Consent

The validity of a consent depends on a number of criteria having been met:

1. The consent must be free, voluntary and genuine. The patient must have the opportunity to choose between consent and refusal without fear, constraint, compulsion or duress.

2. Consent to treatment can be given only by a person who has the legal competency to give it. One can assume that everyone had the legal competency to consent unless there is a court order appointing a guardian1 to make medical capacity – just because a patient continues to be legally competent does not mean that he/she has a mental capacity. For further discussion on obtaining consent from an incompetent patient, see appropriate section.

3. The patient must have the mental capacity to consent to treatment. This means that the patient must be capable of understanding what it means to consent to treatment, the nature of his/her condition, the information and opinions given and the treatment being

1 The Court Order must specifically state that the guardian is appointed for the purpose of making medical decisions as a person can be declared incapable of making financial decisions, but capable of making health care decision.

suggested. If the patient does not have mental capacity to consent to treatment, consent must be obtained from a substitute decision maker (See appropriate section).

4. The patient must be adequately informed about the proposed treatment including:

   a. the nature and purpose of the proposed treatment
   b. the intended benefits
   c. material or probable risks or complications
   d. the consequences of foregoing all treatment
   e. alternatives available

The treating health professional must provide the patient with the relevant information necessary to make the decision to undergo the treatment, i.e. – **What would be a reasonable person in this patient's situation want to know before consenting?** 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 (Rebil v. Hughes, {1980} 2 S.C.R 880). Therefore, if the chance of a risk occurring is high, the patient must be informed about it. Also, if the chance of a risk occurring is not high, but the risk itself is serious (e.g. – death, paralysis, etc.), it too should be disclosed.

1. The Consent must be specific to the treatment to be performed. In the case of surgery, the patient should be advised of any possible alternative procedures, extensions and

2. additional procedures and be asked to consent to them as well. Additional procedures that have nothing to do with the original operation but are discovered to be convenient at the time or even beneficial may not be performed except in the case of an emergency.

2. The patient must be given the opportunity to ask questions and to receive understandable answers.

3. There must be no misrepresentation of important information.

Responsibility for Obtaining

The treating health professional i.e. the person performing the procedure is responsible for ensuring that the patient or his/her substitute decision maker has given an informed consent for treatment. This declaration is based on the position that whoever is proposing the treatment is in the best position to explain the risks/benefits/alternatives to the patient, and answer the questions of the patient.

A printed explanation sheet for a particular treatment is an acceptable tool to assist the treating health professional in disclosing the information required for a patient to give an informed consent. However, it does not absolve the treating professional from responsibility for ensuring that the patient has been adequately and correctly informed.

The task of obtaining consent cannot be delegated to learners who do not possess the knowledge necessary to adequately present all the pertinent risks, benefits and alternative treatments. In general, most physician residents could be expected to have sufficient knowledge. However, the ultimate responsibility for ensuring that a valid consent had been

obtained remains with the treating health professional. **Obtaining consent for treatment to be performed by a physician cannot be delegated to other staff members.**

Documentation of Consent

Although consent is a communication process and not just a piece of paper, some form of documentation is required to ensure proper treatment is received by the patient. Furthermore, the consent form may be used as evidence that the patient, or his/her substitute decision maker, actually consented to the proposed treatment.

After the patient has been informed and has had an opportunity to ask questions concerning the proposed treatment and any alternatives to the proposed treatment, a consent form must be signed. **All blank spaces on the consent form should be filled in**. If "none" or "not applicable" is the appropriate entry, it should be so stated.

FOR CONSENT TO TREATMENT, ONLY CONSENT FORMS APPROVED BY GASHA AND LISTED ON THE APPENDIX TO THIS POLICY MAY BE USED. (This does not apply to consent to research). All consent to treatment forms must be approved by the Quality Management Department.

It is recommended that the treating health professional record in the patient's health record the content of the conversation with the patient which explained the proposed treatment, the anticipated benefits, the reasonably probable risks the patient's apparent understanding and culminated in the patient's informed consent to the treatment.

Witnessing

In signing as a witness, the individual merely certifies that the patient named on the form was the person signing it. The witness is not certifying the validity of the consent itself. While any competent adult can witness the signature, it is recommended that the person obtaining the consent should conclude the process by completing the consent form and witnessing the patient's signature.

If the patient or his/her substitute decision maker is unable to physically sign the form (e.g.: illiterate), then the signature of a second witness is required on the consent form. A notation should be made on the consent form to indicate that the form was read to the patient.

Duration of Consent

A Consent is valid until:

1. the treatment consented to is performed

2. the patient's condition changes

3. the patient withdraws the consent

4. further risks become known, or alternative treatments become available

Unless the patient explicitly states that his/her consent is being withdrawn, there is a presumption that that patient's consent is still in force and that there is no need to explicitly verify it. However, as the length of time between obtaining the consent and performing the procedure increase, so does the likelihood that the patient's condition may have changed. Therefore, it is strongly suggested that the treating health professional performing a procedure should reconfirm that the patient has had the procedure fully explained and had an opportunity to ask questions. The appropriateness of the length of the time between discussing the proposed treatment with the patient, and actually performing the procedure will vary from service to service. It is critical that an assessment of the validity of a consent be based on the principles outlined in this Policy. A consent of questionable validity should be brought to the attention of the treating health professional.

According to the law, if a patient loses capacity to consent after consenting to a procedure, the consent continues to be valid, unless there is a change in the patient's medical condition which makes the treatment no longer appropriate. However, depending on the circumstances, it may be prudent to complete the consent process with a substitute decision maker. If the circumstances have changed since the original consent, consent must be re-obtained from the substitute decision maker (See appropriate section).

Refusal to Consent/Withdrawal of Consent

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

1. the patient is suffering from certain specified communicable diseases for which treatment is mandatory under the *Health Act*, or

2. the patient has been forcibly confined to a psychiatric institution pursuant to mental legislation of the *Criminal Code*. (If a person has been forcibly confined under the *Hospital Act*, he/she does not automatically lose his/her right to consent to treatment or refuse treatment. However, under the 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 follows that the patient is also capable to refuse treatment).

Next-of-kin cannot give or refuse consent on behalf of a competent patient.

To continue without consent is considered battery. If a competent patient refuses treatment, it is important to explain the clinical consequences of that decision to the patient and document the discussion carefully in the progress notes and on the consent form.

The principles of consent also encompass the patient's right to withdraw consent**.** It is important that the patient understands the consequences of withdrawing consent. This should be made clear in any documentation provided to a patient and in discussions with him/her. The refusal and or withdrawal of consent and associated risks should be noted on the progress notes and on the general consent/release form appendix.

Consent by Telephone

When possible, consent should be obtained in person from the patient or his/her substitute decision maker. However, 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 substitute decision maker in accordance with the *Hospitals Act*. The treating health professional who has placed the telephone call must determine:

1. the relationship between the patient and the person to whom the call was placed; and

2. the person's willingness to give or refuse consent to treatment on behalf of the patient

The same requirements for informed consent exist 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 treating health professional must explain the following:

1. the nature of the patient's condition for which treatment is proposed

2. the proposed treatment

3. the probable risks and benefits associated with the proposed treatment

4. any reasonable alternative forms of treatment along with the risks and benefits of such alternative treatment

5. the consequences of foregoing all treatment.

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.**

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

1. the reason why the patient was unable to consent

2. the name of the person placing the call

3. the time and date of the call

4. the number called and the name of the person to whom the call was placed

5. the name of the person monitoring the call as the witness

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

Emergencies

The only time (apart from legislative authorization) a patient can be treated without consent is in a medical/legal emergency. For a medical/legal emergency to exist, the following criteria are necessary:

1. the patient is unable to consent, and next-of-kin are unavailable

2. there is an immediate threat to the life or health of the patient

3. treatment cannot be delayed without increasing risk or harm to the patient

If the procedure can be delayed, the situation is not a medical/legal emergency and arrangements must be made to obtain consent.

In a medical/legal emergency, the treating health care professional should:

1. 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;

2. Proceed with the treatment to which a reasonable, prudent individual in the patient's circumstances would be expected to consent; and

3. Obtain consent from the patient or substitute decision maker as soon as is practical.

If, in a medical/legal emergency, the decision to proceed with a procedure is made after consultation with a colleague, etc., it would be prudent to document this in the patient's health record. In circumstances where the physician has knowledge of the patient's prior refusal consent to the proposed treatment, the physician should not provide the treatment against the express known wishes of the patient. Reference to an Advanced Directive may be instructive, if the patient has one (See appropriate section).

Incompetent Patients

In Nova Scotia, there is a presumption of competence on the part of a patient. Section 51 of the *Hospitals Act* states as follows:

"*The person shall be presumed to be competent or capable of consenting until a psychiatrist determines that the person is not".*

The attending physician may be asked to make determinations of competence. Where the attending physician has reason to believe that a patient is not legally competent to manage his/her estate, a psychiatric consultation is requested. It is important to remember that just because a patient is not legally competent to manage his/her affairs, he/she may still retain the capacity to consent to treatment. As well, patients who are legally competent may not have the capacity to consent to treatment.

Patients or persons admitted to that part of the hospital designated for the treatment of individuals suffering from a psychiatric disorder, may be examined by a psychiatrist as the need arises (or at the very least, once every three months for the first year during which the person is

a patient, and at least once every twelve months thereafter) to determine whether or not that person is competent to administer his/her estate. The Act also sets out specific requirements for the documentation related to the factors to be used in determining competency, the declaration of competency, the revocation of the declaration of competency and other matters.

Substituted Decision Maker:

If the patient is not capable of consenting, consent must be obtained from one of the following persons, in this order of priority:

1. legally appointed guardian2

2. a person who the patient, when competent, appointed as his/her proxy under either the *Powers of Attorney Act* (enduring power of attorney), or the *Medical Consent Act3*

3. spouse

4. next-of-kin (children 19 years old or older, either parent, brother or sister); or

5. the public trustee

ANYWHERE WHERE THE TERM "SPOUSE" IS USED IN THE *HOSPITALS ACT*, THE PHRASE "OR COMMON-LAW PARTNER" IS TO BE ADDED.

With regard to consent to treatment, Section 54(2) of the *Hospitals Act* now states:

> If a person in a hospital is found by declaration of capacity to be incapable of consent to treatment then that person may be treated either upon obtaining the consent of the guardian of that person, if he/she has one, or if he/she has not a guardian upon obtaining the consent of his/her 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.

Please Note: Staff at Long Term Care Institutions or homes for the developmentally disabled cannot give consent for patients under their care unless they have been formally appointed guardians of the patient by the court.

The treating health professional must ensure that the person consenting on behalf of the patient understands:

1. the nature of the condition for which the treatment is proposed

2. the proposed treatment

2 The *Incompetent Persons Act* permits the court to appoint a guardian for an incompetent person and every guardian so appointed shall have the care and custody of the person and the management of the person's estate until legally discharged.

3 The *Medical Consent Act* allows a person who is of the age of majority (19) and capable of giving consent to medical treatment, to appoint, in writing, another person of the age of majority as his/her guardian to consent to medical treatment on his/her behalf in the future, should the need arise.

3. the probable benefits and risks of the proposed treatment

4. any reasonable alternative forms of treatment, along with the risks and benefits of such alternative treatments

5. the consequences of foregoing treatment.

Advanced Directives (Living Wills)

Living Wills are not legally binding in Nova Scotia. However, Living Wills 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 would become incapacitated.

Some treating health professionals have expressed frustration with Living Wills which are vague to the extent that it is difficult to determine the actual wishes of the patient. Patients are therefore encouraged to (in addition to having a Living Will) appoint a proxy pursuant to either the *Medical Consent Act* or the *Powers of Attorney Act* (See appropriate section).

Minors

There is no designated "age of consent" in Nova Scotia. If, in the judgment of the treating health professional, the patient has the capacity to consent (e.g. is mature enough to understand the nature and consequences of the treatment decision), the patient can give his/her own consent.

The fact that the minor (a person under the age of 19 years of age) is living on his/her own, self-supporting or married (emancipated minor) may be taken into consideration.

An exception to the principle that a competent minor can consent to his/her own treatment is found in the *Human Tissue Gift Act*, R.S.N.S, c.215 (as amended) which forbids minors from making decisions on tissue donations.

A minor who is a ward of a Children's Aid society or for whom a guardian has been appointed has all the rights a child would have if living with his/her parents. The organization or guardian having custody of the child has as much right, duty and responsibility as a parent has, but no more. Therefore, a minor in such circumstances may consent to treatment just as any minor might do.

Note: The younger the patient is and the more significant the procedure, the greater the care that should be taken to evaluate capacity. This may involve obtaining a second opinion from another physician and documentation of the assessment by the second physician.

Medications

Ideally, consent should not be obtained after the administration of sedating medication, or while the patient is under the influence of drugs, alcohol or in shock, as the circumstances may be such as to render the patient incapable of giving an informed and voluntary consent. This does not mean that a consent given under any of these circumstances is necessarily invalid.

However, the circumstances are such as to raise the possibility, so it is the policy of the GASHA that consent will be obtained under these circumstances only under extenuating (such as immediate need for analgesia) circumstances. Capacity to consent must be assessed at the time that consent is sought and the deciding factors are the ability to understand that nature, risks and benefits of the proposed treatment. Documentation of the following is critical:

1. the circumstances surrounding obtaining consent after the administration of medication

2. the assessment of capacity is critical

Anaesthetic Consent

The administration of anaesthetics is considered to be an invasive procedure independent of the actual surgery. Therefore, all the principles of an informed consent apply. The anaesthetist should discuss the form of anaesthesia proposed, alternative methods if any, any exclusions imposed by the patient and any material risks of the proposed anaesthesia. This must be documented in the patient's health record, indicating that the discussion took place and the patient agreed.

~~**Consent for Organ Donation**~~

~~Refer to Organ and Tissue Donation Policy – Nursing Policy #1-430~~

~~**All the criteria for an informed consent apply.**~~ **Legislation changed January 18, 2021. Until the Consent for Organ and Tissue Donation policy is published, refer to** NSHA CL-OD-005 Organ and Tissue Donor Identification and Referral.

Consent for Autopsy

When deemed necessary, the attending physician or his/her delegate will approach the substitute decision maker for permission to perform an autopsy. **All criteria for an informed consent apply**. Particular attention should be paid to documenting the extent of the autopsy to which the substituted decision maker has consented.

In Nova Scotia, the Medical Examiner has the right to take charge of a body if it appears that:

1. there is a reasonable cause to suspect that the person died by violence, undue means or culpable negligence

2. the person died in a place or under circumstances requiring an inquest under statute

3. the cause of death is undetermined

4. the person died in jail or prison (See the *Fatality Inquiries Act,* Section 5(1))
Under any of these circumstances, a consent for autopsy is not required.

Consent for Research

As with all consents, consent to research must be voluntary and informed. If a patient is to participate in a research study, additional information must be made available, over and above the information required for a valid consent to treatment. There must be complete and candid

disclosure of all the facts and probability of risk which a reasonable person in the patient's position may be expected to consider before consenting to participation in a research study.

The consent for research must be documented separately from any treatment consents, and must comply with the consent requirements both as discussed in this Policy and as outlined by the Research Ethics Committee of the GASHA.

The research participant is free to withdraw consent at any time. However, it is important that the participant be made aware of any consequences of withdrawing consent during the research study.
It is suggested that one person on the research team be designated to inform potential research participant and to answer questions. This should be the person who is in the best position to discuss with the participant the possible harms, benefits and uses of the research. If the research involves a medical intervention/treatment component as well as a research component, the consent should be obtained by the treating health professional. Particular care must be taken to ensure a voluntary consent if the researcher is also the care-giver as the patient may feel an undue influence to participate. Such undue influence may act to invalidate a consent.

Consent to Photography

If the treating health professional requires a photograph or video of a patient for the patient's health record for clinical teaching or for reproduction in a medical publication, the health professional must explain the purpose of the request to the patient and must obtain the patient's consent on the form intended for this purpose.
There is a separate policy for consent to interviews and photography for public relations purposes.

RELATED DOCUMENTS

CONSENT TO INVESTIGATION, TREATMENT OR OPERATIVE PROCEDURE –Appendix A-3-11

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