



Consent to Treatment

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College of Physicians and Surgeons of Ontario. *Consent to medical treatment and the need to document* (Issue 3 2013); *Determining capacity to consent* (July 2007); *Reducing Barriers to Care* (April 2009)

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OTHER REFERENCES: Consent to Treatment: Frequently Asked Questions

COLLEGE CONTACTS: Physician Advisory Services

Consent to Treatment

INTRODUCTION

Patient autonomy and respect for personal dignity are central to the provision of ethically sound care. In order to exercise their autonomy, patients have the moral and legal right to make decisions regarding their treatment when they are capable of doing so. If the patient is not capable of making a decision with respect to a treatment, this decision is made by a substitute decision-maker on behalf of the patient.¹ The legal right of patients to give or refuse consent to treatment has been codified in the *Health Care Consent Act, 1996 (HCCA)*.^{2,3}

Physicians have a legal and professional obligation to obtain consent prior to providing treatment. This policy highlights many of the expectations set out in the *HCCA*; however, it does not contain an exhaustive catalogue of the requirements in the *HCCA*.⁴ Physicians must be aware of, and comply with, all of the requirements in the *HCCA*. If physicians are unsure of their legal obligations in specific circumstances, the College advises them to obtain independent legal advice.⁵

The policy also contains some obligations that are not codified in the *HCCA*, but are professional expectations of physicians set out by the College.

PRINCIPLES

The key values of professionalism articulated in the College's Practice Guide – compassion, service, altruism and trustworthiness – form the basis for the expectations set out in this policy. Physicians embody these values and uphold the reputation of the profession by:

1. Respecting patient autonomy with respect to health-care goals, and treatment decisions;
2. Acting in the best interests of their patients;
3. Demonstrating professional competence, which includes meeting the standard of care;
4. Communicating and collaborating effectively with patients and substitute decision-makers, physicians and other health-care providers; and
5. Participating in self-regulation of the medical profession by complying with the expectations set out in this policy.

PURPOSE & SCOPE

This policy sets out expectations of physicians regarding consent to treatment.⁶

Treatment⁷ is defined in the *HCCA* as anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose,⁸ and includes a course of treatment,⁹ plan of treatment¹⁰ or community treatment plan.¹¹

1. This policy uses the terms "patient(s)" and/or "substitute decision-maker(s)" instead of "person(s)", the term used in the *Health Care Consent Act, 1996*.

2. *Health Care Consent Act, 1996*, S.O. 1996, c.2, Schedule A (hereinafter *HCCA*).

3. As stated in Sections 6 and 7 of the *HCCA*, 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 for the protection of the person's health, and removal of tissue for transplantation. Nor does it 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.

4. The policy only addresses consent to treatment and as such, only contains key elements of this portion of the *HCCA*. This policy does not address the portions of the *HCCA* that regulate Admission to Care Facilities and Personal Assistance Services.

5. For example, from the Canadian Medical Protective Association or other legal counsel.

6. This policy does not contain expectations regarding consent to the collection, use, or disclosure of personal health information. For more information on these matters, see the College's Confidentiality of Personal Health Information policy. This policy also does not contain expectations regarding consent to the collection, use, or disclosure of personal health information for research purposes or consent to participation in research. For more information on these matters, see the College's Physicians' Relationships with Industry: Practice, Education and Research policy.

7. Section 2(1) of the *HCCA*.

8. The following are not considered to be treatment as outlined in Section 2(1) of the *HCCA*: 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, the admission to a hospital or other facility, a personal assistance service, a treatment that in the circumstances poses little or no risk of harm to the person, and anything prescribed by the regulation as not constituting treatment.

9. Section 2(1) of the *HCCA* states that a 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.

10. Section 2(1) of the *HCCA* states that a 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.

11. Section 2(1) of the *HCCA* and Section 1(1) of the *Mental Health Act*, R.S.O. 1990, c. M.7 (hereinafter *Mental Health Act*) state that a community treatment plan means a plan that is a required part of a community treatment order. See Section 33.7 of the *Mental Health Act* for a description of what the plan contains.



POLICY

Physicians must comply with the expectations set out in this policy when obtaining consent for treatment.

Physicians must obtain valid consent before treatment is provided. In order for consent to be valid it must:¹²

- be obtained from the patient if they are capable with respect to the treatment or from the incapable patient's substitute decision-maker;
- be related to the treatment;
- be informed;
- be given voluntarily; and
- not be obtained through misrepresentation or fraud.

The College advises physicians to consider and address language and/or communication issues that may impede a patient's ability to give valid consent. Physicians may consider using family members instead of third-party interpreters;¹³ however, physicians are advised to take the potential limitations of doing so into account. Research suggests that relying on family members to help overcome language and/or communication issues may have some limitations, including: language limitations, difficulty understanding medical terms, conflicts within families, and important information being deliberately or accidentally omitted. Physicians must use their professional judgment to determine whether it is appropriate to use family members as interpreters, taking into consider-

ation the specific circumstances of the case (e.g., the family dynamics, the seriousness of the condition and/or treatment, etc.).

Additionally, the College advises physicians that consent may need to be revisited after it has been obtained if there are any significant changes in the patient (e.g., their health status, health-care needs, specific circumstances, capacity, etc.) or treatment (e.g., the nature, expected benefits, material risks, and material side effects, etc.). Physicians are advised that the passage of time may increase the risk that these changes will arise and that consent may need to be obtained again.

Patients and substitute decision-makers can refuse or withhold consent to a treatment. In addition, consent can be withdrawn at any time, by the patient if they are capable with respect to the treatment at the time of the withdrawal, or by the patient's substitute decision-maker if the patient is incapable with respect to the treatment at the time of the withdrawal.¹⁴ The College requires physicians to respect the patient's or substitute decision-maker's decision to exercise their legal right to refuse, withhold or withdraw consent, even if the physician does not agree with the decision.¹⁵

Additional expectations regarding consent to treatment are set out in detail in the sections below. In brief, the framework and key requirements for consent to treatment are as follows:

12. Sections 10(1) and 11(1) of the *HCCA*.

13. Physicians are reminded that they must have consent to share patient's personal health information with any interpreter. For more information, see the College's Confidentiality of Personal Health Information policy.

14. Section 14 of the *HCCA*.

15. For example, it is inappropriate for a physician to end the physician-patient relationship in situations where the patient chooses not to follow the physician's treatment advice. For more information, see the College's Ending the Physician-Patient Relationship policy.

Consent to Treatment

What circumstances require consent	Physicians must obtain consent for all treatment, as defined in the <i>HCCA</i> .
Who to obtain consent from	In order for consent to be valid, it must be obtained from the patient if they are capable with respect to the treatment or from the substitute decision-maker if the patient is incapable with respect to the treatment.
What elements are required for consent	In order for consent to be valid, it must be related to the treatment, informed, given voluntarily, and not obtained through misrepresentation or fraud. If any of these requirements are not met, the consent may not be valid. When obtaining consent, the College requires physicians to engage in a dialogue with the patient or substitute decision-maker, regardless of whether or not physicians use supporting documents, including consent forms.
How consent can be given	Consent to treatment may be express (explicit) or implied (implicit).
When and what to document	The College requires physicians to document information regarding consent to treatment in certain circumstances, and recommends that this be done in all other circumstances.
When emergency treatment can be provided without consent	In emergencies, treatment can only be provided without consent when certain requirements are met.

If physicians are unsure of whether the consent obtained is valid, treatment must not be provided until the physician is assured that valid consent has been obtained. The obligation to ensure that valid consent has been obtained always rests with the physician who is proposing the treatment. The College advises physicians that obtaining consent can be delegated¹⁶ to other health-care providers only when the physician proposing the treatment is assured that the health-care provider has the knowledge, skill and judgment required to obtain consent.

What Circumstances Require Consent

Physicians must obtain consent for all treatment,¹⁷ that 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.¹⁸

Who to Obtain Consent From

If a patient is capable with respect to a treatment, the physician must obtain consent from the patient directly.

If a patient is incapable with respect to a treatment, the physician must obtain consent from the substitute decision-maker, who will give or refuse consent on the patient's behalf.

16. This policy uses the term delegation in the colloquial sense; it does not refer to the delegation of controlled acts, as defined in the College's Delegation of Controlled Acts policy.

17. Section 10(1) of the *HCCA*.

18. Section 2(1) of the *HCCA*. See footnotes 9, 10 and 11 for definitions of a course of treatment, plan of treatment, and community treatment plan and footnote 8 for more information on what is not considered treatment.



Capacity

A patient is capable with respect to a treatment¹⁹ if they are able to understand the information that is relevant to making a decision about the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.²⁰ The capacity to consent to a treatment varies according to the individual patient and the complexity of the decision at hand.

Physicians are entitled to presume that a patient is capable with respect to a treatment unless there are reasonable grounds to believe otherwise.²¹ 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 to the treatment.

Capacity must be considered at various points in time and in relation to the specific treatment being proposed. Capacity is fluid, it can change over time, and depends on the nature and complexity of the specific treatment decision. A patient may be incapable with respect to a treatment at one time and capable at another, and be incapable with respect to some treatments and capable with respect to others.²²

Minors

The test of capacity to consent to a treatment is not age-dependent and as such, physicians must make a determination of capacity to consent to a treatment for a minor just as they would for an adult. If a minor is capable with respect to a treatment, the physician must obtain consent from the

minor directly even if the minor is accompanied by his or her parent(s) or guardian(s).

Substitute Decision-Makers and Incapable Patients

When a physician determines that a patient is incapable with respect to a treatment, consent must be obtained from the incapable patient's substitute decision-maker.

A) Identifying the substitute decision-maker

The physician must identify and obtain consent from the highest-ranking substitute decision-maker that satisfies all of the requirements set out in the *HCCA*.

The hierarchy of individuals/agencies who may give or refuse consent on behalf of an incapable patient is as follows:²³

1. Guardian, if authorized²⁴
2. Attorney for personal care,²⁵ if authorized
3. Representative appointed by Consent and Capacity Board, if authorized
4. Spouse or partner²⁶
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 adoption)²⁷
9. Public Guardian and Trustee

19. This policy only speaks to the capacity to give or refuse consent to treatment and not, for example, the capacity to make financial decisions or to make decisions regarding one's personal health information.

20. Section 4(1) of the *HCCA*.

21. Sections 4(2) to (3) of the *HCCA*.

22. Section 15 of the *HCCA*.

23. Section 20(1) and 21(5) of the *HCCA*.

24. 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.

25. As defined in Section 46 of the *Substitute Decisions Act, 1992*, S.O. 1992, c. 30, an attorney for personal care is a person authorized by a patient in a written power of attorney for personal care document to make decisions about personal care on behalf of the patient, in the event that the patient is incapable.

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

27. Section 20(10) of the *HCCA*.

Consent to Treatment

The substitute decision-maker for the incapable patient is the highest-ranking person on this list that is:²⁸

- capable with respect to the treatment;²⁹
- at least 16 years old, unless he or she is the incapable patient's parent;
- not prohibited by court order or separation agreement from having access to the incapable patient or giving or refusing consent on his or her behalf;
- available;³⁰ and
- willing to assume the responsibility of giving or refusing consent.

The substitute decision-maker for the incapable patient may be more than one person within the same rank,³¹ provided that they meet the above requirements.

If the highest-ranking person on this list does not satisfy all of these requirements, physicians must move to the next person on the list who meets the requirements.

When identifying the substitute decision-maker, physicians must take reasonable steps to ensure that the requirements of the *HCCA* are satisfied; that is, the individual is the highest-ranking substitute decision-maker that satisfies the

HCCA requirements stated above. In so doing, physicians are entitled to rely on the representations made by an individual about their relationship to the patient, unless there is reason to believe the representations are false.

b) Substitute decision-making

The *HCCA* requires that the substitute decision-maker give or refuse consent in accordance with the most recent and known wish expressed by the patient, while capable and at least 16 years old at the time. If no wish is known, or the wish is impossible to comply with or not applicable to the circumstances, the substitute decision-maker must act in the incapable patient's best interests.³²

Wishes can be expressed in writing,³³ orally, or in any other manner.³⁴ Later wishes expressed while capable, whether written, oral, or in any other manner, prevail over earlier wishes.³⁵

To determine the incapable patient's best interests, the substitute decision-maker must:³⁶ consider any values and beliefs the incapable patient held while capable; any wishes the incapable patient expressed that are not binding according to the above criteria; the impact of providing and not providing the treatment on the patient's condition or well-being;³⁷ whether the expected

28. Section 20(2) of the *HCCA*.

29. The test of capacity is the same for substitute decision-makers as it is for patients. See Section 4(1) of the *HCCA* and the section "Capacity" of this policy for more information.

30. Section 20(11) of the *HCCA* states that a person is available if it is possible, within a time that is reasonable in the circumstances, to communicate with the person and obtain a consent or refusal.

31. For the purposes of this policy, the terms "person", "individual" and "substitute decision-maker" will be used in the singular.

32. Section 21(1) of the *HCCA*.

33. This may include advance care planning documents, what is commonly known as an 'advance directive', in a power of attorney, or in another form. For more information about advance care planning see the College's Decision-making for the End of Life policy.

34. Section 5(1) and (2) of the *HCCA*.

35. Section 5(3) of the *HCCA*.

36. Section 21(2) of the *HCCA*.

37. Section 21(2) (c) 1 and 2 of the *HCCA*. This will include assessing whether the treatment is likely to: improve the incapable patient's condition or well-being; prevent their condition or well-being from deteriorating; reduce the extent to which, or rate at which, their condition or well-being is likely to deteriorate; and whether their condition or well-being is likely to improve, remain the same or deteriorate without the treatment.



benefit of the treatment outweighs the risk of harm; and whether a less restrictive or less intrusive treatment would be as beneficial.

Physicians have a legal obligation³⁸ to ensure that substitute decision-makers understand the requirements for giving or refusing consent as set out in the *HCCA*.³⁹ If a physician is of the view that the substitute decision-maker is not acting in accordance with the *HCCA*,⁴⁰ the physician may apply to the Consent and Capacity Board for a determination as to whether this is the case and how to proceed.⁴¹ If two or more substitute decision-makers of the same rank, who rank ahead of all others, and who satisfy all the requirements for substitute decision-makers, disagree about whether to give or refuse consent, then the Public Guardian and Trustee will make the decision.⁴²

c) Incapable patients

If a physician determines that a patient is incapable with respect to a treatment, where possible, the College requires the physician to inform the incapable patient that a substitute decision-maker will assist them in understanding the proposed treatment and will be responsible for making the final decision.

If the patient disagrees with the finding of incapacity, the College requires physicians to advise the patient that they can apply to the Consent and Capacity Board for a review of the finding of incapacity.^{43, 44} Additionally, if the patient disagrees with the involvement of the present substitute decision-maker, the College requires physicians to advise the patient that they can apply to the Consent and Capacity Board to appoint a substitute decision-maker of their choice.^{45, 46} The College advises physicians to take reasonable steps to assist the patient if they express a desire to exercise either of these options.⁴⁷

When appropriate, the College requires physicians to involve the incapable patient, to the extent possible, in discussions with the substitute decision-maker.

What Elements are Required for Consent

Regardless of whether consent is given by the patient if they are capable or the incapable patient's substitute decision-maker, the following are the elements required for consent to treatment:

38. See paragraph 23 of *M. (A.) v. Benes*, 1999 CanLII 3807 (ON CA).

39. See Section 21 of the *HCCA*.

40. Section 21 of the *HCCA*.

41. Section 37 of the *HCCA*.

42. Section 20(6) of the *HCCA*.

43. Section 32(1) of the *HCCA* allows a patient to file for a review of the finding of incapacity.

44. If the patient intends to or has filed an application to the Consent and Capacity Board to, for example, review the finding of incapacity, Section 18(3) of the *HCCA* requires the physician to 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*.

45. Section 33(1) of the *HCCA* allows a patient to apply to the Consent and Capacity Board for appointment of a representative to give or refuse consent on his or her behalf.

46. For more information on the obligations of physicians when they are informed that there will be an application to the Consent and Capacity Board, see section 18(3) of the *HCCA* and footnote 44 of this policy.

47. For example, by providing the patient with the contact information for the lawyer referral service of the Law Society of Upper Canada.

Consent to Treatment

1) Consent must relate to the treatment⁴⁸

Consent must relate to the specific treatment being proposed and provided.

Unless it is not reasonable to do so in the circumstances, physicians are entitled to presume that consent to treatment includes:⁴⁹

- consent to variations or adjustments in the treatment, if the nature, expected benefits, material risks⁵⁰ and material side effects of the changed treatment are not significantly different; and
- consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks⁵¹ or material side effects of the treatment as a result of the change in the setting in which it is administered.

2) Consent must be informed⁵²

Prior to obtaining consent, physicians must provide information about the nature of the treatment, its expected benefits, its material risks⁵³ and material side effects, alternative courses of action and the likely consequences of not having the treatment.⁵⁴

The information that must be provided is what a reasonable person in the same circumstances would require in order to make a decision about the treatment.⁵⁵ The information that must be provided will vary and therefore, must be determined on a case-by-case basis. The information must include material risks that are relevant

for a broad range of patients, and information, including material risks, that is particularly relevant for the specific patient.

In determining what information must be provided, including which risks are material, physicians must consider the specific circumstances of the patient,⁵⁶ and use their clinical judgment to determine what information must be provided.

The College requires physicians to engage in a dialogue with the patient if they are capable or the incapable patient's substitute decision-maker regarding the nature of the treatment, its expected benefits, its material risks and material side effects, alternative courses of action and the likely consequences of not having the treatment. This requirement exists regardless of whether or not physicians use supporting documents, including consent forms,⁵⁷ to facilitate the provision of this information.

Providing patients or substitute decision-makers with information can only facilitate decision-making if that information is provided, reviewed and understood prior to giving or refusing consent to a treatment. Ultimately, physicians must be satisfied that the information is understood and as such, the College requires that physicians take reasonable steps to facilitate the comprehension of the information provided.⁵⁸

48. Section 11(1)(1) of the *HCCA*.

49. Section 12 of the *HCCA*.

50. See the next subsection of this policy, "2) Consent must be informed", for more information on material risks.

51. See the next subsection of this policy, "2) Consent must be informed", for more information on material risks.

52. Section 11(1)(2) of the *HCCA*.

53. The courts have stated that a material risk is one that a reasonable person in the patient's position would want to know about before deciding whether to proceed with the proposed treatment. The material risks that must be disclosed are risks that are common and significant, even though not necessarily grave, and those that are rare, but particularly significant.

54. Section 11(3) of the *HCCA*.

55. Section 11(2) (a) of the *HCCA*.

56. This may include, but is not limited to, the patient's values, lifestyle, profession, hobbies, etc.

57. Supporting documents can also include, patient education materials or pamphlets, information from the Compendium of Pharmaceuticals and Specialties, etc.

58. For example, by considering the plainness of the language used, the modality in which the information is communicated, any literacy issues, etc.



Physicians are required to provide a response to requests for additional information about the treatment.⁵⁹

3) Consent must be given voluntarily⁶⁰

Consent cannot be given under duress. If physicians believe that consent is not being freely given, they must ensure that there has been no coercion.

4) Consent must not be obtained through misrepresentation or fraud⁶¹

Physicians must be frank and honest when interacting with patients, including when conveying the information about the proposed treatment.

How Consent Can be Given

The *HCCA* states that consent to treatment may be express or implied.⁶²

Express consent is direct, explicit, and unequivocal. Express consent can be given orally or in writing.

Implied consent is inferred from the words or behaviour of the patient, or surrounding circumstances, such that a reasonable person would believe that consent has been given, although no direct, explicit, and unequivocal words of agreement have been given.

Although the *HCCA* states that consent to treatment may be express or implied, the College strongly advises physicians to obtain express

consent, particularly when the treatment is likely to be more than mildly painful, carries appreciable risk, will result in ablation of a bodily function, is a surgical procedure or an invasive investigative procedure, or will lead to significant changes in consciousness.

When and What to Document

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

When a treatment is likely to be more than mildly painful, carries appreciable risk, will result in ablation of a bodily function, is a surgical procedure or an invasive investigative procedure, or will lead to significant changes in consciousness, the importance of documentation increases. As such, in these circumstances, the College requires physicians to document in the patient's record information regarding consent to treatment.

In all other circumstances the College recommends that physicians always document in the patient's record information regarding consent to treatment.

59. Section 11(2)(b) of the *HCCA* requires that physicians provide a response when asked for more information about the nature of the treatment, its expected benefits, its material risks and material side effects, alternative courses of action, and the likely consequences of not having the treatment.

60. Section 11(1)(3) of the *HCCA*.

61. Section 11(1)(4) of the *HCCA*.

62. Section 11(4) of the *HCCA*.

Consent to Treatment

Physicians must use their professional judgment to determine what information to document in the patient's record, taking into consideration the specific circumstances of the case. However, the College recommends that the following be included: the date of the dialogue; who was involved in the dialogue; the specific material risks that were communicated; any unique material risks related to the specific circumstances of the patient that were communicated; the risks of not treating the condition that were communicated; whether consent was given or refused and by whom; and the date that consent was given or refused. Physicians are also advised to document findings of incapacity and the identity of the substitute decision-maker.

When Emergency Treatment can be Provided Without Consent

The *HCCA* states that there is an emergency if the patient 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.⁶³

In emergencies, physicians must obtain consent from a patient who is apparently capable with respect to the treatment, unless, in the opinion of the physician:⁶⁴

- the communication required in order for consent to be given or refused cannot take place because of a language barrier or because the patient has a disability that prevents the communication from taking place;

- steps that are reasonable in the circumstances have been taken to find a practical means of enabling the communication to take place, but no such means has been found;
- the delay required to find a practical means of enabling the communication to take place will prolong the suffering that the patient is apparently experiencing or will put the patient at risk of sustaining serious bodily harm; and
- there is no reason to believe that the patient does not want the treatment.

In emergencies, when a patient is incapable with respect to the treatment, physicians must obtain consent from the incapable patient's substitute decision-maker, unless, in the opinion of the physician, the delay required to obtain a consent or refusal on the patient's behalf will prolong the suffering that the patient is apparently experiencing or will put the patient at risk of sustaining serious bodily harm.⁶⁵

Physicians must not provide treatment in emergencies if they have reasonable grounds to believe that the patient, while capable and at least 16 years of age, has expressed a wish applicable to the circumstances to refuse consent to the treatment.⁶⁶

If consent is refused by a substitute decision-maker in an emergency, the treatment may be administered despite the refusal if, in the opinion of the physician, the substitute decision-maker has not complied with the requirements for substitute decision-making outlined in the *HCCA*.⁶⁷

63. Section 25(1) of the *HCCA*.

64. Section 25(3) of the *HCCA*.

65. Section 25(2) of the *HCCA*.

66. Section 26 of the *HCCA*.

67. Section 27 of the *HCCA*. See the section "Substitute Decision-Makers and Incapable Patients" of this policy for more information on the requirements for substitute decision-making.



After administering treatment in an emergency without consent, physicians must promptly note in the patient's record the opinions they held at the time in regards to the requirement(s) stated above, upon which they relied.⁶⁸

Treatment may continue only for as long as is reasonably necessary to find a practical means of enabling communication to take place⁶⁹ or to find the incapable patient's substitute decision-maker,⁷⁰ and physicians must ensure that reasonable efforts are made to find a practical means of enabling communication to take place or to find the incapable patient's substitute decision-maker, as the case may be.⁷¹

If during the course of treatment, the patient becomes capable in the opinion of the physician, the patient's own decision governs.⁷²

68. Section 25(5) of the *HCCA*. See sections 25(2) and 25(3) of the *HCCA* for the requirements.

69. Section 25(7) of the *HCCA*.

70. Section 25(6) of the *HCCA*.

71. Section 25(8) of the *HCCA*.

72. Section 25(9) of the *HCCA*.

CONSENT TO TREATMENT



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