MLST Submissions to CPSO re Policy on

Consent to Medical Treatment

The Medico-Legal Society of Toronto (MLST) was founded in 1950 by a group of doctors and lawyers to promote medical, legal and scientific knowledge, cooperation and understanding between the professions in the interest of justice and in the best interests of patients and clients. The MLST's Submissions Committee is mandated to advocate on behalf of and in alignment with the MLST's mission, vision and objects, and to monitor and respond to government and stakeholder issues as well as calls for input.

The CPSO has invited feedback from all stakeholders to assist the CPSO in updating its *Consent to Medical Treatment* policy, currently being reviewed. Accordingly, the following submissions have been developed by the MLST and are hereby respectfully conveyed to the CPSO.

Strengths

- Straightforward summary of the HCCA and SDA
- Paraphrases legislation in way that makes it quick and easy to understand for physicians
- Sets out principles/duties in emergency and non-emergency situations

Weaknesses

- There are some errors
- There are some gaps
- There are not enough practical illustrations and examples

Overarching Suggestion

- The CPSO should consider adopting a format for this policy similar to that used by the Law Society of Upper Canada in its Rules of Professional Conduct. Such a format allows for the "rule" to be set out first, followed by a commentary which can provide further explanation as to the rationale for the rule and/or nuances and/or examples and illustrations as to how it is applied in practice, without needing to resort to the use of footnotes.

Specific Comments on the Current Policy

Principles section:

1. The five principles currently listed in the policy are not incorrect, and it is certainly open to the CPSO to frame and prioritize its own principles. What seems to be lacking, however, is a straightforward statement along the lines of "no treatment without consent", (which is the subtitle to section 10 of the HCCA), but with some important exceptions.

2. This section would also be enhanced by some clarification that consent is only required for treatment or plans of treatment that are *proposed* by a health practitioner, ie, that the principle of patient autonomy does not extend to permitting patients to demand treatment that a health practitioner cannot or is not prepared to offer.

Duties Section

Determination of Capacity

3. As currently drafted, this section implies that the first duty on a physician is to determine if a patient is "capable of consenting". There are 2 problems with this wording that recur throughout the document.

   First, to be more accurate, it is important to clarify that the "capacity" is in respect of *making a decision about* the treatment being proposed, ie, either refusing *or* consenting.

   Second, the HCCA does not explicitly impose a duty on a physician to first make a determination of a patient's capacity. Rather, it imposes a duty on a physician not to administer treatment to a person unless consent has been given by that person, if capable, or on that person's behalf by an SDM, if incapable (s. 10). It also allows for a person to be presumed capable with respect to treatment, unless there are reasonable grounds to believe otherwise (subs 4(2) and (3)).

   In practice, the assessment of a person's capacity and the proposal of a treatment do not happen in a step wise fashion, but rather, a physician engages in a process of discussion(s) with a patient, often in the presence of family members, by the end of which the physician may have no reason to depart from the presumption of capacity,

and accepts the patient's decision. Alternatively, the physician may have doubts around the patient's capacity, but be provided with a consent conveyed by both the patient and by the individual who would be the patient's SDM if the patient was incapable. In that scenario, the physician can proceed to administer the treatment, as it has been consented to by the appropriate individual, regardless of any determination of capacity. In reality, it is only in the circumstances where it is not clear that the physician has been provided with a treatment decision which satisfies the requirements of the HCCA that it is necessary for the physician to embark upon a determination of the patient's capacity.

To suggest that each time a physician proposes a treatment, a determination must first be made as to the patient's capacity, will be setting physicians up to be non-compliant with this policy most of the time, since in the realities of medical practice, it is usually not necessary, and it is not practically possible to do it.

4. With respect to determining capacity, where there are other helpful Guidelines from the CPSO on this topic, they should be explicitly and prominently cross-referenced. For example, the July 2007 article in *Dialogue*, "Determining Capacity to Consent" is considered by physicians to be very helpful. In fact, much of the format and content of that guideline might be incorporated directly into the new CPSO policy.

5. More guidance by way of examples could be provided as to what constitutes
   - reasonable grounds to consider departing from the presumption of capacity (ie, what are some "red flags")
   - a substitute decision-maker being "capable, available and willing": when should physicians consider moving to another SDM in the hierarchy outlined under s. 20 HCCA?
   - A physician's obligations (if any) when bypassing a purported SDM because the physician is not satisfied that the person is capable.

This is the sort of information which would fit nicely in commentary areas.

<u>Obtaining Informed Consent</u>

6. More guidance could be given to physicians as to how to go about providing the necessary information and asking and answering questions, in the process of obtaining an informed consent and assessing whether there is a need to dig deeper with respect to the capacity issue. For example, they should be encouraged to engage the assistance of translators when necessary, and in some cases, to consult with other specialists. (For example, a hematologist faced with an adolescent's refusal to consent to a significant

treatment can consult with an adolescent psychiatrist on the capacity issue; or an adult internist with a geriatric psychiatrist, etc.)

7. The policy refers to the fact that unless it is not reasonable to do so in the circumstances, a physician may presume that consent to treatment includes consent to variations or adjustments in the treatment, and to the continuation of the same treatment in a different setting unless there is a significant change, but makes no mention of the fact that a consent to treatment on an incapable person's behalf includes authority to consent to another treatment that is necessary and ancillary to the treatment, and to consent to the incapable person's admission to a hospital for the purpose of the treatment (with one exception). [Ss. 23 and 24 of the HCCA]. This authority can be quite helpful in resolving certain situations (such as the use of restraint in order to safely deliver a medication or other treatment to an incapable patient), and so merits reference.

8. More guidance by way of examples could be provided as to what constitutes
   - "information that a reasonable person in the same circumstances would require in order to make a decision about the treatment";
   - whether a particular risk is "material";
   - what is an "implied consent";
   - when should physicians ensure consent is *explicitly* sought for components of a treatment plan (e.g. when the component of the plan would have significant implications for short and long term outcomes and well-being)
   - how does a physician "*ensure* that there has been no coercion"? (or should it be reworded, "*believe* that…"?)
   - when would a physician have reason to believe, in an emergency situation, that the person would not want the treatment? [E.g. *Mallette v. Shulman* (card in wallet refusing blood transfusion)*;* what about power of attorney documents; "living wills"; level of care forms; information from EMS?]

   Again, this is the sort of information which would fit nicely in commentary areas.

<u>Challenges</u>

9. The CPSO policy states that a physician must "reasonably assist the patient if he or she expresses a wish to exercise the options outlined above" [ie, if the patient disagrees with the involvement of an SDM]. It would be helpful if more specific guidance could be provided as to what constitutes "reasonable assistance", including the specific contact information for rights advice and/or the CCB (phone #'s and websites).

10. The paragraphs in which the CPSO policy outlines the criteria which must be considered by a substitute decision maker when making a decision on behalf of a person would also benefit from some further commentary delineating some examples of the distinction between a "prior capable wish applicable to the circumstances" (which is binding if not impossible to comply with), and other (non-binding) wishes, given that there is now a body of case law from decisions of the Consent and Capacity Board and appeals taken from those decisions.

    Also, the policy wording currently significantly truncates the factors which must be considered under subs 21(2)c of the HCCA (the risk/benefit analysis), but which are very important, and so consideration should be given to setting these factors out in more detail, albeit paraphrased.

11. The policy currently states that "if a physician is of the view that the SDM is not acting in accordance with the *HCCA*, he or she can call the Office of the Public Guardian and Trustee". This is incorrect. The Office of the PGT has a role to play only as the decision-maker of last resort if there is no other qualified SDM (ie, age 16 or over, capable, available and willing) or is in fact the patient's guardian appointed under the SDA. This is distinct from the situation where a qualified SDM seems to be making a "wrong" decision ie, one that does not seem to comply with the criteria set out in section 21 of the HCCA. Rather, the policy should state that if the physician is of the view that the SDM is qualified, but is not acting in accordance with the proper decision-making principles, he or she can bring an application (called a "Form G") to the Consent and Capacity Board for a determination of that issue. The policy should also probably advise physicians in that situation to seek legal advice and/or support if contemplating such an application.

12. The obligation not to treat until the patient's disagreement with the involvement of an SDM is resolved is currently the subject matter only of a footnote in the Policy. As this is relatively important information, it should probably be incorporated more directly into the Policy.

<u>Emergency Treatment</u>

13. The CPSO policy currently states that in the case of emergency treatment of a capable person without consent, "it is critical that the physician document his or her actions in the patient's chart". There are 2 problems with this statement. First, the requirement in the HCCA (subs 25(5)) is that the physician "promptly note in the person's record the *opinions*" held by the physician which are required by the particular section of the

emergency treatment provisions of the HCCA on which the physician relied. That is, subs. 25(5) does not so much oblige the physician to document "actions" (although he or she presumably should and would), but, in addition, to document the *rationale* for the physician's decision to treat or not to treat in the emergency, in the absence of consent.

Second, this requirement applies whether the person treated without consent was capable (but not able to communicate) or incapable, and that's not clear in the policy.

14. This same section of the CPSO policy fails to note the obligation on a health practitioner after providing emergency treatment without consent, to ensure that reasonable efforts are made to find the SDM or to obtain a capable patient's own consent once able (subs 25(8) and (9).

Documentation

15. The CPSO should also provide further guidance to physicians with respect the advisability of documentation around matters such as:

- the informed consent discussion;
- the patient's capacity/incapacity;
- the provision of information to the patient about the consequences of a finding of incapacity;
- the patient's SDM – who is it, is the SDM capable, available, and willing, and has been provided with the information necessary in order to provide an informed decision;
- explanations provided to SDMs as to their obligations in making a decision on behalf of a patient (as found in s. 21 of the HCCA), in situations where the physician has doubts that the SDM is following these principles;
- efforts made to effect communication with the patient and/or SDMs in and after an emergency.

Other

16. The CPSO ought to give its consideration to how to draft and apply a Policy re Consent to Treatment to the medical reality that most, if not all, medical treatment is a trial of treatment. That is, physicians could benefit from some guidance as to the need to re-evaluate treatment proposals based on a patient's response or lack thereof, and what implications this will have for consent. Is the process for obtaining consent the same

when considering and discussing definitive treatment versus the initiation of a *trial* of treatment and/or its continuation or discontinuation? While these considerations have particular relevance in the context of the CPSO's review of its End of Life Policy, and should be further fleshed out there, it would nevertheless be wise to at least reinforce the need for appropriate re-evaluation of treatment and its implications for either an anticipatory or renewed consent process in this policy.

17. In addition, or alternatively, the CPSO might want to consider including in both this policy and the EOL policy a dispute resolution process, or to cross-reference to a dispute resolution process policy, ie, a guideline for how to try to resolve disagreements over treatment decisions before they ripen into applications being made to the CCB.

Conclusions

The MLST sincerely hopes that the CPSO will find our submissions helpful. We recognize that the nature of our submission, if adopted, is such that much of the current content of the policy will be retained, but with a significant change in format and some additional content, much of which has not yet been developed in precise detail nor provided by us. That being the case, we expect that the CPSO will benefit from inviting another round of submissions once it is in a position to circulate a new draft of the Policy. The MLST would be pleased to part of such a process.