

Health Care Consent Act

Briefing Note

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Note: This Briefing Note is not intended to provide legal advice but is only intended to provide general information about the Health Care Consent Act, 1996. For legal advice in relation to specific circumstances, please consult with a lawyer.

Overview

Putting the Health Care Consent Act in Context

The principle of informed consent is enshrined in common law, that is, the decisions of judges in court cases.

This means that physiotherapists are required to obtain the consent of patients prior to rendering any physiotherapy services, including assessment or treatment.

The obligation to obtain consent is documented in the College's Code of Ethics for physiotherapists as well as in the Essential Competency Profile for Physiotherapists in Canada (Dimension Five, Element 3). The common law has confirmed the requirement for all health practitioners, including physiotherapists, to obtain the informed consent of their patients prior to proceeding with assessment or treatment.

However, these obligations did not adequately address situations in which patients are incapable of giving consent.

To deal with this issue, as well as to provide a summary from the court cases on the circumstances on when and how consent must be obtained, The Health Care Consent Act (HCCA) was passed.

It is important to recognize that the HCCA does not and cannot deal with every aspect of consent because the law is constantly evolving in this area. This means that in circumstances that are not specifically covered by the HCCA, health practitioners still have an obligation to obtain consent.

With this in mind, in every circumstance in which a physiotherapist engages in a patient care activity, consent should be obtained, even in circumstances where there does not seem to be a specific obligation to do so under the HCCA. The legislation that has been developed to provide caregivers with guidance does not deal with every foreseeable circumstance in which consent may be needed nor does it replace the common law obligations to obtain an informed consent when there is no specific statutory obligation to do so.

Among the aspects of consent that are not dealt with solely by the HCCA are circumstances in which people need decisions made on their behalf on an ongoing basis. This is dealt with by both the HCCA and the Substitute Decisions Act (SDA).

The HCCA only briefly deals with consent for the collection, use and disclosure of personal health information. Generally speaking, in Ontario, guidance in this area is provided by the provincial Personal Health Information Protection Act (PHIPA), although in some circumstances the federal Personal Information Protection and Electronic Documents Act (PIPEDA) may also be relevant. For more information on a physiotherapist's obligations in this area, please see College's briefing materials on privacy:

- Personal Information Protection and Electronic Documents Act (PIPEDA): Are You Ready for the New Privacy Model?
- A Supplementary Guide to the Personal Health Information Act, 2004

Despite these general cautions, the obligations for obtaining consent in the HCCA are quite broad and do mandate the requirements for obtaining consent in the following circumstances:

- Respecting treatment, as it is defined in the Act
- Respecting admission to care facilities
- Respecting personal assistance services

The HCCA in Brief

The Health Care Consent Act is intended to:

- provide rules with respect to consent to treatment that apply consistently in all settings
- facilitate treatment for persons lacking the capacity to make decisions about such matters
- enhance the autonomy of persons for whom treatment is proposed by:
 - allowing persons found to be incapable to apply to the Consent and Capacity Board for a review of the finding
 - allowing incapable persons to request that a representative of their choice be appointed by the Board for the purpose of making decisions on their behalf concerning treatment
 - requiring adherence to the treatment wishes expressed by persons while capable and after attaining 16 years of age
- promote communication and understanding between health practitioners and their patients or patients
- ensure a significant role for supportive family registrants when a person lacks the capacity to make a decision about a treatment
- permit intervention by the Public Guardian and Trustee only as a last resort in decisions on behalf of incapable persons concerning treatment

The Health Care Consent Act is administered by the Ministry of Health and Long-Term Care and applies to most regulated health care practitioners, including physiotherapists. It does not apply to dental technologists, opticians and pharmacists. The legislation addresses the capacity of an individual to consent to treatment, and sets out a hierarchy of substitute decision makers to whom decisions can be referred should a person be deemed incapable.

Key Principles Governing Consent to Treatment

Principle 1

Before treatment is administered, the physiotherapist who proposes the treatment must ensure that consent to the treatment is obtained from the patient if he/she is capable, or the patient's substitute decision maker, if the patient is incapable.

Principle 2

The health practitioner who proposes the treatment (this person may be different from the person who actually administers treatment) is responsible for formulating an opinion about the capacity of the patient to consent or refuse to consent to the treatment.

Principle 3

The consent must relate to the proposed treatment, must be informed, must be given voluntarily, and must not be obtained through misrepresentation or fraud.

Principle 4

An informed consent means that the patient, or substitute decision maker if the patient is incapable, has received the information that a reasonable person in the same circumstances would require about the treatment, including information about the nature, benefits, material risks and side effects of the treatment, alternative courses of action, and the likely consequences of not having the treatment.

The physiotherapist, if she or he is obtaining the consent must also answer the patient's or substitute decision maker's questions related to such matters.

Principle 5

Only a health practitioner who has the knowledge to obtain an informed consent, including being able to answer the patient's or substitute decision maker's questions about the treatment, is able to obtain an informed consent for the treatment.

Principle 6

A physiotherapist proposing a treatment is responsible for ensuring that informed consent for that treatment is obtained. A physiotherapist performing a treatment proposed by another health practitioner should be able to rely on the informed consent obtained by that health practitioner if it is reasonable to do so (e.g., the consent is documented in the patient record and there has been no material change in circumstances).

Principle 7

A prudent physiotherapist should not begin an individual treatment/procedure without prior discussion with the patient, i.e., a review of what the physiotherapist would like to do.

Principle 8

Although one registrant of a health care team can determine capacity and obtain consent for a treatment plan, if the physiotherapist administering the treatment is in doubt about whether consent was obtained, or the patient refuses the treatment or does not appear to be aware of the treatment, the physiotherapist should not proceed (except in an emergency).

If a patient refuses the treatment, the practitioner who obtained the consent to the treatment plan should be contacted to verify that consent was obtained. If it was, but the patient continues to refuse the treatment, the practitioner who proposed the treatment plan should be informed. If the patient is capable, the health practitioner should be informed that the patient has withdrawn consent. If the patient is not capable, the substitute decision maker should be informed of the patient's refusal and confirm whether consent is still given. In this case, the substitute decision maker is expected to follow the patient's previously expressed wishes.

Principle 9

The expressed wishes that a substitute decision maker must follow are wishes that a person expressed:

- while he/she was capable
- after he/she had reached the age of 16 years

Principle 10

The Act does not define an age at which a person is deemed old enough to be capable of giving consent to their health care decisions.

The Act does require a person to be capable and at least 16 years of age in order for their expressed wishes to be taken into account if at some point he/she becomes incapable of giving consent on his or her own behalf.

Key Aspects of the Act

Physiotherapists seeking to apply the Act should be familiar with the following important concepts, embedded within the Act.

Definition of Treatment

Many of the activities performed by physiotherapists on a one-time visit are excluded from the definition of treatment. For example the assessment of a patient's condition, the taking of a patient's health history and the communication of assessment results are specifically excluded from the definition of "treatment". This means these activities are also excluded from the requirements for obtaining consent as spelled out in the Act. See the section "In Practice: Treatment" for more information.

However, the common law requirement to obtain consent for the performance of these activities still applies. While physiotherapists are not obliged to follow the HCCA in such cases, they may choose to do so for the sake of consistency. Further, by choosing to follow the HCCA, the physiotherapist may, in certain situations, be able to take advantage of certain provisions, such as protection from liability when on reasonable grounds they believe that:

- the treatment was provided because the patient consented to the treatment
- the treatment is not provided because the patient refused the treatment
- the treatment was withheld or withdrawn because the patient consented to a plan of treatment including withdrawing or withholding treatment

Similar protections from legal liability exist when, in good faith, a physiotherapist administers emergency treatment without consent.

Determination of Capacity

There are no set rules for determining the capacity of a patient. A physiotherapist can begin by assuming that the patient is capable. If he/she has reasonable grounds to believe his/her patient is incapable,

the physiotherapist should determine capacity by exercising reasonable professional judgment.
Emergencies

The definition of “emergency” in the Act is quite broad and includes circumstances in which a patient “is apparently experiencing severe suffering.” See the section “In Practice: Emergency Treatment” for more information.

Even when a patient is capable, emergency treatment can be administered without consent in cases where a language barrier or other communication difficulties make it impossible to obtain informed consent without delay.

Emergency treatment does not preclude the need to obtain informed consent, but it can be carried out until communication is possible (in the case of a capable patient) or a substitute decision maker is found (in the case of an incapable patient).

Non-Treatment Decisions

The HCCA permits substitute decisions for admission to a care facility, such as a nursing home, and for decisions about personal assistance services relating to the routine activities of daily living. Physiotherapists working in complex continuing care or providing care to significantly disabled people will need to become familiar with these provisions, which parallel those used in obtaining consent to treatment.

Substitute Decision Makers

The Act does not require physiotherapists to obtain formal statements from family confirming their validity as substitute decision makers. However, they do have to ascertain whether the family registrant knows of any formally appointed substitute or higher ranking substitute decision maker. Unless it is unreasonable to do so, physiotherapists can rely on a person’s assertion that he/she is entitled to act as a substitute decision maker.

The list of substitute decision makers defined in the HCCA is hierarchical. In other words, the substitute decision maker who is closest to the top of the list is the one who would normally be asked to make the decision, if he/she is available. If this person is not available, the consent for the incapable patient’s treatment should be sought from the next person down the list. See the section In Practice: Substitute Decision Makers for the list of decision makers.

Consent and Capacity Board

It is important to have a general understanding of the role of the Board. The Board can review incapacity findings as well as appoint representatives to make decisions about specific treatments or about several kinds of treatments or about treatment decisions in general. If a physiotherapist believes a substitute decision maker is not acting in accordance with either a person’s expressed wishes (made when the person was capable and after having reached the age of 16 years) or his/her best interests, the physiotherapist may apply to the Board for direction.

Treatment, once begun, does not have to not be suspended pending the result of a review of a finding of incapacity. The Consent and Capacity Board may also give mandatory directions to the substitute

decision maker to ensure that the patient's expressed wishes or best interests are acted upon.

Notification of Incapacity Finding

The Act protects the rights of incapable patients by requiring health practitioners to adhere to guidelines, developed by their respective health regulatory colleges, on when and how such patients should be notified of the consequences of the finding, including the right of review.

Guidelines on Providing Information to Incapable Patients

The College of Physiotherapists of Ontario has developed Guidelines on Providing Information to Incapable Patients. They are found in Appendix Two: Guidelines on Providing Information to Incapable Patients.

It is important to note that the HCCA requires health practitioners to comply with these guidelines, once they have been established by the regulatory colleges.

Liability Protections

The Health Care Consent Act offers both practitioners and substitute decision makers protections from liability.

When a physiotherapist acts in good faith within the provisions of the Act, he/she is not liable when, on reasonable grounds, he/she believes that:

- the treatment was provided because the patient or the substitute decision maker consented to the treatment
- the treatment is not provided because the patient or the substitute decision maker refused the treatment
- the treatment was withdrawn or withheld because the patient or the substitute decision maker consented to a plan of treatment that included withdrawing or withholding treatment
- the treatment was administered without consent because the circumstances indicated the existence of an emergency, as defined by the Act and/or
- the treatment was not administered despite the existence of circumstances indicating an emergency, as defined by the Act, because consent was refused in prior expressed wishes

Further, a person who gives or refuses consent to a treatment on behalf of an incapable patient is not liable for giving or refusing consent, provided the decision was made in good faith. Physiotherapists are entitled to rely on the assertion of a substitute decision maker that he/she is, in fact, the highest ranking available substitute, unless it is not reasonable to do so.

In Practice: Treatment

Defining Treatment

“Treatment” is anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and can include a course or plan of treatment or community treatment plan.

A course of treatment is a series or sequence of similar treatments administered to a patient over a period of time for a particular health problem.

A plan of treatment is a plan that:

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

The Act says that consent can be obtained for a plan or course of treatment. If the individual treatment is part of a course or plan for which consent has been obtained, then separate consent for each treatment is not required as long as the patient is capable of making decisions about all the treatments that are part of the course or plan.

What is NOT Considered Treatment?

Under the Act, treatment does not include:

- the assessment of a patient’s capacity
 - to consent to treatment, admission to a care facility or a personal assistance service
 - to manage property
 - to make personal care decisions
 - for any other purpose
- the assessment or examination of a patient to determine the general nature of a patient’s condition
- the taking of a patient’s health history
- the communication of an assessment* or a diagnosis
- the admission of a person 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 patient
- activities prescribed by the regulations under the HCCA as not constituting treatment (at the time this Briefing Note was written, no activities are prescribed in this way)

Although these activities do not constitute treatment under the Act, as noted previously, consent in accordance with the common law is still needed.

In certain specified cases, the Act allows a health practitioner to “opt in” by deciding to proceed as if the treatment were included in the definition. That is, a physiotherapist may choose to apply the HCCA even if the activity is excluded from the definition of treatment. The activities that are currently specified in this way are:

- the assessment or examination of a patient to determine the general nature of a patient’s condition
- a treatment that in the circumstances poses little or no risk of harm to the patient

It is important to note that if a physiotherapist decides to proceed as if these activities were included in the definition of treatment, then the HCCA applies, just as if they were included in the treatment definition.

Consent for such activities can be arrived at in the same manner as treatments included in the Act. “Opting in” allows physiotherapists to take advantage of certain provisions, such as protection from legal liability:

- if the treatment is part of a course of treatment
- by making the treatment part of a plan of treatment
- in some cases (e.g., in low-risk procedures), merely by proceeding on the basis that the Act applies

“Necessary and Ancillary Treatment”

A complex part of the Act relates to “necessary and ancillary treatments”.

Since a patient’s capacity for giving consent can vary depending upon the kind of treatment proposed and its implications, sometimes an issue arises because a patient may not be capable of giving consent to the primary treatment, for example the surgical treatment for lung cancer, but is capable of giving or refusing consent to an ancillary treatment, for example, oxygen therapy.

Because it would be impractical to have the substitute decision maker give consent to the primary treatment (the surgery), and yet allow the patient to refuse consent to the necessary and ancillary treatment (the oxygen therapy), the legislation provides that the substitute decision maker would also make the

decision about necessary and ancillary treatments. In other words, in circumstances where the primary treatment would not be efficacious without the occurrence of the ancillary treatment, the substitute decision maker would make the decision for the “package” of treatment. (Though of course, the substitute would be expected to take the patient’s wishes and best interests into account when making the decision.)

The terms themselves are not specifically defined in the Act. The dictionary definition of ancillary is “subservient” or “subordinate”. “Necessary” medical treatment has been interpreted in the common law as treatment that is reasonably required, or indicated, for the health of the patient concerned. The reasonable interpretation, therefore, is that necessary and ancillary treatment is treatment that is subordinate to the primary treatment, but reasonably required for the patient’s health.

It is important to note that informed consent to necessary and ancillary treatment should be obtained from the substitute decision maker as part of the consent to a plan of treatment.

In Practice: Consent

Under the Health Care Consent Act, no health practitioner in Ontario can provide treatment unless consent is obtained. The consent must:

- relate to the treatment being proposed
- be informed
- be voluntary
- not be obtained through misrepresentation or fraud

Consent is required for all treatment provided by health practitioners, except treatment provided in an emergency situation. However, as noted previously, the definition of treatment in the HCCA does not necessarily include all the services that physiotherapists provide. When a physiotherapist provides care that is not included in the HCCA definition of treatment, he/she still has a common law obligation to obtain consent.

In some circumstances, the physiotherapist’s obligation can also be met through the incorporation of these services into a plan of care that has been consented to, or through the use of the emergency provisions in the Act, which are relatively broad.

Informed Consent

Under the Act, consent is informed if, before giving it, the patient or substitute decision maker received the information that a reasonable person in the same circumstances would require in order to make a decision. As well, the health practitioner must have provided responses to requests for further information.

Information must be provided on:

- the nature of the treatment
- the expected benefits of the treatment
- alternative courses of action
- the material risks and side effects of the treatment
- the likely consequences of not having the treatment

Material risks and side effects are:

- those which are probable or likely to occur
- those which are possible rather than probable but can have serious consequences
- anything else which would be considered relevant to know by a reasonable person in the same circumstances

Provided there are no significant changes in the nature, expected benefits, material risks or material side effects of the treatment, a physiotherapist may presume that consent to treatment includes consent to variations or adjustments in the treatment and to the continuation of the same treatment in another setting.

Consent can be written or oral, express or implied. A facility may require a written form in specified situations; however, just because a consent form is signed does not necessarily mean that there is informed consent.

The fact that a signed consent form exists does not necessarily mean that informed consent was given by a patient or a substitute decision maker.

This is an important consideration in physiotherapists' understanding of their obligations around consent. The obtaining and the giving of informed consent is a process — in other words it requires a dialogue between both the person proposing the treatment and the person giving the consent for the treatment. This dialogue must provide opportunities for the health practitioner and the patient to discuss the issue, consider treatment options, ask questions and have them answered.

Genuine consent involves a meeting of the minds. Simply asking a patient whether he/she consents to the treatment, whether this is done verbally, or by asking him/her to read and sign a form, does not constitute fulfilling a physiotherapist's obligation to obtain informed consent.

Documenting Consent

Despite the fact that a signed form does not constitute an informed consent, it is still very important for physiotherapists to document the fact that the discussion related to consent did occur.

To assist physiotherapist in documenting their consent discussion, the College provides a sample consent form in Appendix III.

Capacity to Give Consent

A patient is capable of giving consent if he/she is able to:

- understand the information that is relevant to making a decision concerning the treatment
- appreciate the reasonably foreseeable consequences of making a decision or not making a decision

Determining Capacity

A physiotherapist must exercise his/her professional judgment about whether the patient is capable with respect to a proposed treatment.

The HCCA requires that practitioners presume that patients are capable of making treatment decisions unless there are some reasonable grounds to believe otherwise.

In this regard, a physiotherapist should not make any presumption of incapacity solely because the patient:

- has a diagnosis of a psychiatric or neurological condition
- is disabled
- refuses the proposed treatment against advice
- requests an alternative treatment

Additionally, there can be no automatic presumption of incapacity just because of a patient's age. This means that patients' ages should be used as an independent factor for determining capacity to give consent.

Indications which may lead to the belief that a person is incapable of making a treatment decision include, but are not limited to:

- evidence of confused or delusional thinking
- the appearance of an inability to make a settled choice about treatment
- severe pain or acute fear or anxiety
- the appearance of severe depression
- the appearance of impairment by alcohol or drugs

- any other observations which give rise to a concern about the person's behaviour or communication.

Any of these factors may lead to the belief that the patient may not be capable of making a decision about the proposed treatment.

If the physiotherapist believes the patient may not be capable of giving consent, then he/she must conduct an assessment to determine whether the patient understands all of the following:

- the condition for which the treatment is proposed
- the nature of the proposed treatment
- the risks, side effects and benefits of the treatment
- the alternatives to the treatment, including the alternative of not having the treatment

If the physiotherapist has determined the person is able to understand the information, the physiotherapist must also assess whether the patient is able to appreciate the reasonably foreseeable consequences of a decision. In reaching this decision, the physiotherapist must be of the opinion that the patient meets one or more of the following criteria:

- the patient is able to acknowledge that the condition for which treatment is recommended may affect him/her
- the patient is able to assess how the proposed treatment or lack of treatment discussed by the provider could affect the his/her life or quality of life
- the patient's choice of treatment is not substantially based on a delusional belief

If the person cannot appreciate any one or more of these factors, the person is not capable of giving consent to the proposed treatment.

As noted above, there is no age threshold for capacity to give consent. Patients of any age are entitled to make their own treatment decisions as long as they understand the relevant information and appreciate the consequences.

A patient can be capable with respect to some treatments and not others. Moreover, a patient may be incapable with respect to a treatment decision at one time, and capable at another time. If a patient regains capacity, his/her own decisions take precedence over any decisions made by a substitute decision maker.

Obtaining Consent

The Act provides that the health practitioner who is proposing the treatment is responsible for obtaining consent. The proposer is the health practitioner who is:

- responsible for deciding what treatment should be offered (this includes a practitioner who is implementing a treatment that has been proposed by means of an identified protocol)
- able to provide the information which a reasonable person needs to give informed consent including being able to answer questions about the information.

In most cases, the health practitioner proposing the treatment will be the person directly obtaining the consent. The following principles should be taken into account if consideration is being given to having another health practitioner obtain the consent.

- Only a health practitioner who has the knowledge to obtain an informed consent including being able to answer the patient's or an incapable patient's substitute decision maker's questions about the treatment is able to obtain an informed consent to the treatment.
- A health practitioner proposing a treatment is responsible for ensuring that informed consent for that treatment is obtained. A physiotherapist performing a treatment proposed by another health practitioner should be able to rely on the informed consent obtained by the other health practitioner if it is reasonable to do so, e.g., the consent is documented in the patient record.
- In order to ensure that consent was obtained, it is prudent that a physiotherapist not begin an individual treatment/procedure without prior discussion with the patient, i.e., a review of what the physiotherapist would like to do.
- If the physiotherapist administering the treatment is in doubt about whether consent was obtained, or the patient refuses the treatment or does not appear to be aware of the treatment, the physiotherapist should not proceed.

How to proceed when there is doubt about whether consent was obtained, or if the patient refuses treatment

In these circumstances the practitioner who obtained the consent to the treatment plan should be contacted to verify that consent was obtained.

If it was, but the patient continues to refuse the treatment, the practitioner who proposed the treatment plan should be informed. If the patient is capable, the health practitioner should be informed that the patient has withdrawn consent. If the patient is incapable with respect to the treatment or procedure, the substitute decision maker should be informed of the patient's refusal and confirm whether the substitute decision maker still consents to the treatment. The substitute decision maker is expected to follow the patient's prior wishes if these wishes were expressed while the patient was capable and after he/she had reached 16 years of age.

If a plan of treatment is proposed for a patient, one health practitioner may, on behalf of the health care team, propose the plan of treatment, determine the patient's capacity with respect to those treatments in the plan of treatment, and obtain consent or refusal to the treatment plan.

Requirement to Obtain Consent

Obtaining consent for treatment is a core concept in the Act.

The Act is very specific in its requirement that treatment not be administered unless:

- the health practitioner proposing the treatment is of the opinion that the patient is capable and has given consent to the treatment
- the health practitioner proposing the treatment is of the opinion that the patient is incapable and a substitute decision maker has given consent to the treatment
- there is an emergency (see In Practice: Emergency Treatment). The circumstances that fall within the emergency treatment provisions are quite broad and a clear understanding of these provisions will be beneficial to physiotherapists wishing to ensure the best care for their patients

The physiotherapist proposing the treatment also must take reasonable steps to ensure that treatment is not administered unless one of the three conditions noted above is met.

Other than the provisions for emergency treatments, the Act does not include any mechanism for physiotherapists who propose a treatment to administer the treatment without the consent of the patient, if he/she is capable, or of a substitute decision maker, if the patient is not capable. The hierarchical nature of the list of substitute decision makers is intended to facilitate obtaining consent on incapable patients' behalf when the primary substitute decision maker cannot be contacted or is unavailable.

However, as noted previously, the definition of treatment in the HCCA does not necessarily include all the services that physiotherapists provide. When a physiotherapist provides care that is not included in the HCCA definition of treatment, he/she still has a common law obligation to obtain consent. In some circumstances, the physiotherapist's obligation can also be met through the incorporation of these services into a plan of care that has been consented to, or through the use of the emergency provisions in the Act, which are relatively broad.

Withdrawal of Consent

Consent for treatment can be withdrawn at any time by the patient if the patient is capable, or by the patient's substitute decision maker if the patient is incapable.

Under case law prior to proclamation of the Act, if consent was withdrawn in mid-treatment and immediate withdrawal would be life-threatening or pose immediate or serious problems to the health of the patient, the practitioner could continue treatment until the threat or problem passed.

Reviews of Incapacity Findings

When a physiotherapist proposes a treatment and determines that the patient is incapable with respect to treatment, the physiotherapist must not start the treatment, if, before the treatment is started he/

she is informed that:

- the incapable patient intends to apply for a review of the incapacity finding to the Consent and Capacity Board
- either the incapable patient or another person intends to apply to the Board to appoint a different representative to make decisions on his/her behalf

Nor can the physiotherapist start the proposed treatment:

- until 48 hours have gone by after he/she was informed of the intended application to the Board without an application being made
- until the application to the Board has been withdrawn
- until the Board has rendered a decision in the matter. This applies provided that none of the parties has informed the physiotherapist that he/she intends to appeal the Board's decision
- if a party to the application before the Board informs the physiotherapist that he/she intends to appeal the Board's decision

These restrictions on initiating treatment do not apply if the physiotherapist is of the opinion that there is an emergency, as defined in the Act.

However, these restrictions do apply in circumstances where the substitute decision maker who would normally make treatment decisions for the incapable person has consented to the treatment on the incapable person's behalf.

In Practice: Substitute Decision Makers

Substitute Decision Makers

Substitute decision makers are individuals who make treatment decisions on behalf of patients who are not capable of making the decision for themselves. In most cases the individual will be a spouse, partner or relative who has agreed to act on the patient's behalf. Other substitutes may be officially appointed.

A substitute decision maker is called when a health care practitioner does not believe that the patient is capable of consenting to a proposed treatment. Because the health care practitioner cannot perform the treatment without consent, he/she must turn to the substitute for a decision.

Qualifications of Substitute Decision Makers

Substitute decision makers must themselves be capable of consenting to or refusing treatment. As well, they must:

- be available

- be willing to assume the responsibility of giving or refusing consent
- be at least 16 years of age, or be the parent of the incapable person
- not be prohibited by a court order or separation agreement from having access to the incapable patient or from giving or refusing consent on the incapable patient's behalf

Hierarchy of Substitute Decision Makers

Priority with respect to treatment decisions made on behalf of an incapable person is defined in the HCCA. Consent should be sought from the highest-ranking substitute decision maker who meets the qualifications described above.

The list of substitute decision makers is:

1. The person's guardian of the person, provided the guardian has authority to give or refuse consent to the treatment
2. The person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment
3. A representative appointed by the Consent and Capacity Board
4. A spouse or partner
5. A child, parent or a children's aid society or other person lawfully entitled to give or refuse consent in place of the parent (This level of the hierarchy does not include a parent who has only a right of access)
6. A parent with right of access only
7. A brother or sister
8. Any other relative of the incapable person
9. The Public Guardian and Trustee, if none of the above meet the qualifications, or in the event two or more equally ranked substitutes cannot agree

As noted previously, this list is hierarchical. In other words, when a substitute decision maker is needed, a physiotherapist would start at the top of the list. If the no one falls into this category who is willing and available to consent to the proposed treatment, the physiotherapist would proceed to the next person on the list. The decision maker at the bottom of the list, the Public Guardian and Trustee, is the decision maker of last resort.

A physiotherapist is entitled to rely on the accuracy of a substitute's assertion about his/her rank and qualifications, unless it is not reasonable to do so in the circumstances.

Roles and Responsibilities of Substitute Decision Makers

The substitute is expected to “step into the shoes” of the incapable person and make decisions based upon the patient’s known wishes or instructions, whether verbal or written. However, these wishes must have been expressed while the incapable patient was capable and was at least 16 years old. If there are no known wishes or instructions or if it is impossible to comply with them, the substitute decision maker must make the decision in the incapable patient’s best interests.

In deciding what the incapable patient’s best interests are, the substitute decision maker must consider the values and beliefs the incapable patient held when capable, and any wishes expressed by the incapable patient with respect to the treatment.

As well, as part of deciding best interests, substitute decision makers must consider whether:

- the incapable patient’s condition or well-being is likely to be improved by the treatment
- the incapable patient’s condition or well-being is likely to improve without the treatment
- the benefit the incapable patient is expected to obtain from the treatment outweighs the risk of harm to him/her
- a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed

Under the Act, a physiotherapist may apply to the Consent and Capacity Board for direction if he/she believes that a substitute decision maker has not acted in accordance with a patient’s expressed wishes or best interests.

The Board will then determine whether the substitute decision maker complied with the requirements spelled out in the legislation and may then give direction to the substitute decision maker to make treatment decisions that are based on the patient’s expressed wishes or best interests.

Right of Substitute Decision Makers to Obtain Personal Health Information about Incapable Persons

The personal health information of all individuals in Ontario, including those deemed incapable under the HCCA, is protected under the Personal Health Information Protection Act (PHIPA) and would not normally be permitted to be used or disclosed without the consent of the person to whom it applies.

However, the HCCA recognizes that in order for a substitute decision maker to give or refuse consent to a treatment proposed by a health practitioner, the substitute is entitled to receive all the information that is needed to make an informed consent on behalf of the incapable patient.

This right supersedes any provisions to the contrary in PHIPA. This means that physiotherapists seeking consent for treatments from substitute decision makers are permitted to provide them with the personal health information about the incapable patients that is needed in order to make informed treatment decisions. Further, personal health information that is in the possession of other health information custodians may also be provided to substitute decision makers when it is required for consent purposes.

It is important to note that this does not mean that the substitute decision maker is entitled to be provided with all the incapable patient's personal health information - the intent is to ensure that the substitute decision maker has the information that is needed for him/her to make an informed consent on behalf of the incapable patient.

In Practice: Emergency Treatment

The Act sets out situations in which a health practitioner may administer treatment without consent. These are generally referred to as "emergencies". The Act defines emergency circumstances quite broadly so physiotherapists will benefit from understanding these provisions.

Emergencies are defined in circumstances where the health practitioner is of the opinion that:

- a patient is apparently experiencing severe suffering or is at risk of sustaining serious bodily harm if the treatment is not administered promptly
- a delay in providing treatment will either:
 - prolong the suffering that the patient is apparently experiencing, or
 - put the patient at risk of suffering serious bodily harm.

In an emergency, a physiotherapist can begin treatment immediately if:

- the patient is capable of giving consent and provides the consent
- the patient is incapable with respect to treatment and there is a substitute decision maker available who gives consent
- the patient is incapable with respect to treatment and it is not reasonably possible to obtain a consent or refusal from the substitute decision maker in time to address the emergency

If the patient is not capable of giving consent and the physiotherapist does not know whether there is an emergency, or the nature of the emergency, the physiotherapist may:

- examine the patient, including conducting diagnostic procedures reasonably necessary to determine if an emergency exists
- give first aid or temporary assistance

Provided there is no reason to believe that the patient does not want treatment, physiotherapists can administer emergency treatment to an apparently capable patient without consent if it is impossible to communicate with the patient due to a language barrier or communication disability.

There are exceptions. The physiotherapist cannot provide treatment if he/she has reasonable grounds to believe that the patient expressed a wish to refuse the treatment while capable. An example would a patient's prior expressed wish to refuse blood transfusions.

As noted above, although the Act does not define an age at which a person is deemed old enough to be capable respecting their health care decisions, the Act does require a person to be both capable and at least 16 years of age to express wishes that are to be taken into account if the person later becomes incapable of being able to give consent on his/her own behalf.

Continuation of Treatment

Under the emergency provisions of the Act, physiotherapists are only permitted to continue to provide emergency treatment for as long as it is reasonably necessary to find a substitute decision maker for an incapable patient or until some means of obtaining consent from the capable patient becomes available. If the patient requiring care becomes capable then his/her own decision to give or refuse consent to continue the treatment would once again come into effect.

Once physiotherapists begin emergency treatments without consent they are obliged to take reasonable steps to find an incapable patient's substitute decision maker or to try to find a means to obtain a capable patient's consent.

Note: These are the general rules. If there is a validated power of attorney for personal care or a guardian of the person, the substitute or guardian continues to make the decisions until there is a formal revocation of the authority. In other words, people who are rendered incapable in an emergency and have designated substitute decision makers should have decisions made on their behalf by these substitutes.

Administrative Obligations

After administering emergency treatment without consent, the physiotherapist must document the particulars of the situation which led to the treatment without consent in the patient record.

Refusal of Treatment by a Capable Person

The basic premise of the legislation is that capable persons have the right to refuse treatment. This principle applies even in an emergency.

In Practice: The Consent And Capacity Board

The Consent and Capacity Board plays a number of roles under the Act.

1. It can review incapacity findings. A patient deemed incapable has the right to apply for a review of the finding to the Board.

In cases where an incapable patient has chosen to challenge the finding of incapacity, treatment must not begin until the appeal of the Board's decision has been completed, the application has been withdrawn, the Board has rendered a decision or 48 hours have passed since the physiotherapist was first informed of the intent to apply without an application being made. If treatment has begun, it need not be suspended pending the Board's decision.

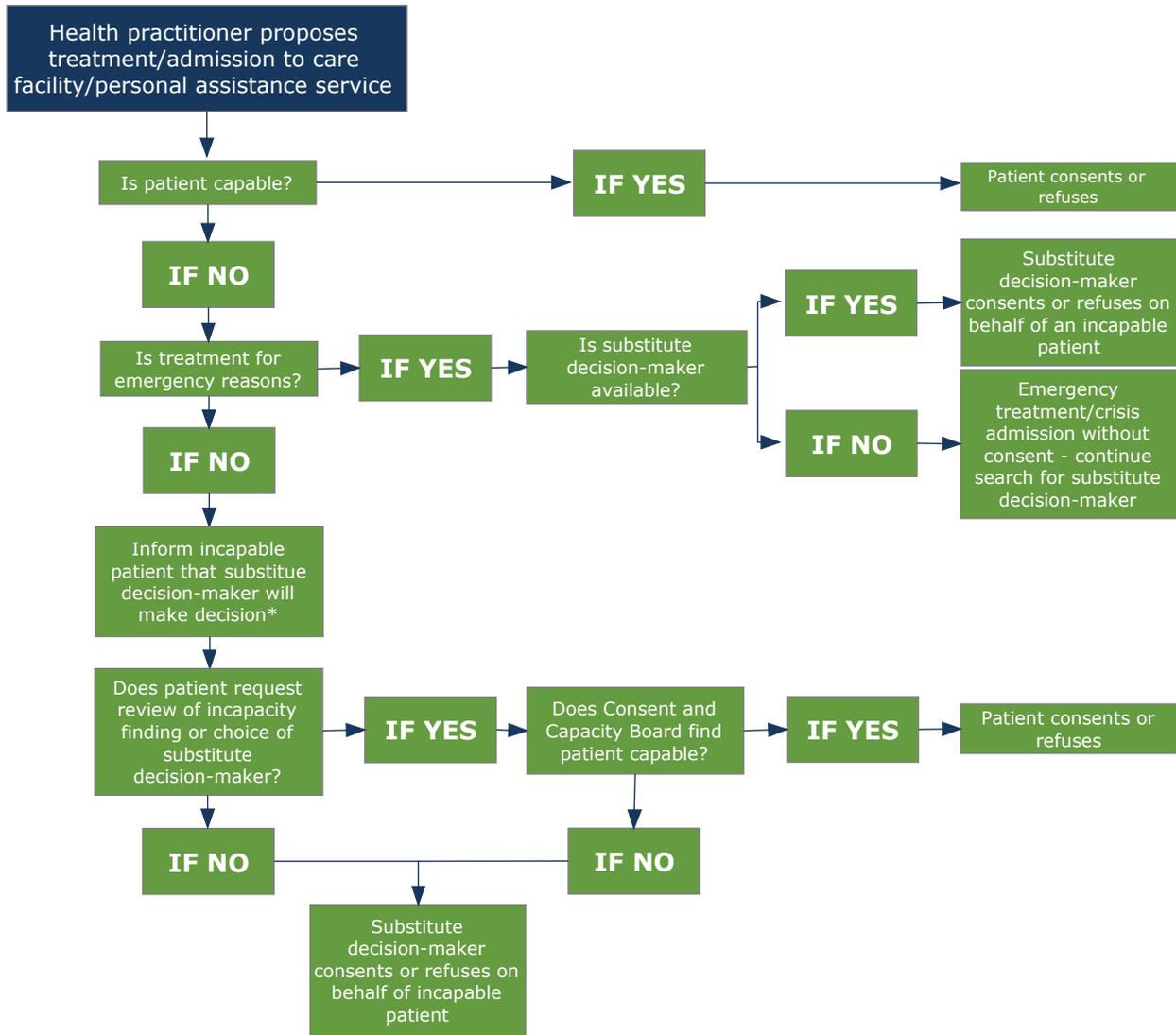
2. It can appoint a representative to give or refuse consent on behalf of an incapable patient. Individuals wishing to be appointed as representatives to give or refuse consent on an incapable patient's behalf can seek Board approval for the appointment. Patients deemed incapable can also apply to the Board to have the Board appoint a representative to give or refuse consent on their behalf.

As with point 1, treatment must not begin until the appeal of the Board's decision is completed, the application has been withdrawn, the Board has rendered a decision, or 48 hours have passed since the physiotherapist was first informed of the intent to apply without an application being made. If treatment has begun, it need not be suspended pending the Board's decision.

3. It can assist health practitioners advocating for the best interests of their patients. For example, a physiotherapist can apply to the Board for direction if he/she believes that a substitute decision maker is not acting in accordance with an incapable patient's previously expressed wishes or best interests.
4. It can assist substitute decision makers and health practitioners by providing directions in assessing an incapable patient's previously expressed wishes. In this case, a substitute decision maker or a health practitioner who has proposed a treatment to an incapable patient who has expressed a wish respecting the treatment may seek direction from the Board, if:
 - the wish is not clear
 - it is not clear that the wish applies to these circumstances
 - it is not clear whether the patient was capable at the time the wish was expressed
 - it is not clear whether the incapable patient was old enough to express wishes (16 years of age)
5. It can assist substitute decision makers by giving them permission to consent to proposed treatments in circumstances where the incapable patient had expressed a wish while he/she was capable, and after he/she had turned 16 years of age, that would require the substitute to refuse the treatment. The Board's role in this respect can be activated by an application from the substitute decision maker or the health practitioner.

It is important to note that if a health practitioner intends to seek the Board's assistance by obtaining direction or departing from a previously expressed wish, the health practitioner must inform the substitute decision maker of this intent.

In Practice: A Decision Tree for Obtaining Consent Under the HCCA



* See Appendix II, Guidelines on Providing Information to Incapable Patients

Appendix I

The Substitute Decisions Act (SDA)

The SDA deals with decision making about personal care or property on behalf of incapable persons. Whereas the HCCA is mostly concerned with the capacity to make decisions in relation to specific treatment, admission to care facilities or the use of personal assistance services, the SDA is concerned with persons who require that decisions be made on their behalf on a continuing basis. It involves the formal appointment of a decision maker through a power of attorney document through the office of the Public Guardian and Trustee (PGT) or through a court appointment.

Some of the major features of this Act are set out below.

- An individual may designate a specific person to make decisions about his/her personal care or treatment in the event he/she becomes incapable. The person may also express his/her wishes or instructions about the kinds of decisions to be made or factors to guide decisions
- The Office of the Public Guardian and Trustee is the government department that deals with personal care and property matters
- Only trained capacity assessors may determine capacity for the purpose of the SDA (i.e., the capacity to make decisions on an ongoing basis). The HCCA requires assessment of capacity to make decisions about a specific treatment, and this is done by the health practitioner who proposes the treatment
- A power of attorney for personal care comes into effect when the person who granted it becomes mentally incapable, unless it states otherwise
- A person under statutory guardianship may apply to the CCB for a review of a finding of incapacity to manage property

Appendix II

Guidelines on Providing Information to Incapable Patients

Section 17 of the Health Care Consent Act indicates that:

“A health practitioner shall, in the circumstances and manner specified in guidelines established by the governing body of a health practitioner’s profession, provide to persons found by the health practitioner to be incapable with respect to treatment such information about the consequences of the findings as is specified in the guidelines.”

The following are the guidelines established by the College of Physiotherapists of Ontario.

1. Whenever reasonable, the physiotherapist informs the incapable patient that a substitute decision maker will be asked to help the patient understand the proposed treatment and will be responsible for making the final treatment decision(s). All information should be communicated in a manner:
 - appropriate to the patient's level of understanding
 - that takes into account the particular circumstances of the patient's condition
 - the characteristics of physiotherapist-patient relationship (e.g. its duration)
2. To the extent permitted by the patient's capacity, the physiotherapist involves the incapable patient in discussions of the proposed treatment with the substitute decision maker.
3. If the patient disagrees with the need for a substitute decision maker because of the finding of incapacity, the physiotherapist clarifies the nature of the patient's concerns and informs the patient of the options he/she may exercise under the Act. These include:
 - applying to the Consent and Capacity Board for a review of the finding of incapacity
 - applying to the Consent and Capacity Board for the appointment of a representative of the patient's choice
 - asking the physiotherapist to find another substitute of the same or more senior rank
4. The physiotherapist uses professional judgment to determine how best to help the patient who wishes to exercise these options and documents his/her actions in the patient record.

Appendix III

Sample Content for Consent Form

I hereby consent to the following treatment; [describe treatment as specifically as possible but in words that are understandable to lay people]. I have been told about the following:

- what the treatment is
- who will be providing the treatment
- the reasons why I should have the treatment
- the alternatives to having the treatment
- the important effects, risks, and side-effects of the treatment
- what would happen if I do not have the treatment

I understand the explanation and have no further questions. My consent is voluntary.

Date

(witness signature)

(signature of patient)

(print name of witness)

(print name of patient)

Appendix IV

Consent and Capacity Board: Forms and Contact Information

The following is a partial list of useful forms available from the Consent and Capacity Board's website at: <http://www.ccboard.on.ca>

Form A: Application to the Board to Review a Finding of Incapacity under Subsection 32(1), 50(1) or 65(1) of the Act

Form B: Application to the Board to Appoint a Representative under Subsection 33(1), 51(1) or 66(1) of the Act

Form C: Application to the Board to Appoint a Representative under Subsection 33(2), 51(2) or 66(2)

Form D: Application to the Board for Directions under Subsection 35(1), 52(1), or 67(1) of the Act

Form E: Application to the Board for Permission to Depart from Wishes under Subsection 36(1), 53(1) or 68(1) of the Act

Form F: Application to the Board with Respect to Place of Treatment under Subsection 34(1) of the Act
Form G: Application to the Board to Determine Compliance under Subsection 37(1), 54(1) or 69(1) of the Act

Form H: Application to the Board to Amend the Conditions of or Terminate the Appointment of a Representative under Subsection 33(7) and (8), 51(6) or 66(6) of the Act

The Consent and Capacity Board has a number of regional offices dispersed throughout the province. The Board may be contacted through the following regional offices:

Toronto 416-924-4961 Fax: 416-924-8873	Penetanguishene (705) 733-3959 Fax: (705) 733-8268
Kingston (613) 530-1081 Fax: (613) 530-2653	Sudbury (705) 673-4614 Fax: (705) 673-7293
London (519) 438-7811 Fax: (519) 660-1525	Thunder Bay (807) 625-0264 Fax: (807) 625-0265
North Bay (705) 494-8450 Fax: (705) 474-5630	Hamilton/Guelph (905) 308-9612 Fax: (905) 522-4357
Ottawa (613) 565-6368 Fax: (613) 565-9605	All applications to the Board should be sent by fax to the appropriate regional number within one hour of signature.

Appendix V

Hierarchy of Substitute Decision Makers

The HCCA defines the hierarchy of substitute decision makers as:

1. The person's guardian of the person, provided the guardian has authority to give or refuse consent to the treatment.
2. The person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment.
3. A representative appointed by the Consent and Capacity Board.
4. A spouse or partner.
5. A child, parent or a children's aid society or other person lawfully entitled to give or refuse consent in place of the parent. (This level of the hierarchy does not include a parent who has only a right of access.)
6. A parent with right of access only.
7. A brother or sister.
8. Any other relative of the incapable person.
9. The Public Guardian and Trustee, if none of the above meet the qualifications, or in the event two or more equally ranked substitutes cannot agree.

Definitions

Attorney for Personal Care: an attorney under a power of attorney for personal care given under the Substitute Decisions Act, 1992

Available: 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

Best Interests: Best interests means the consideration of:

- the incapable person's values, beliefs and expressed wishes
- whether the treatment will benefit the incapable person
- whether the incapable person's condition or well-being is likely to be improved by the treatment

- whether the incapable person's condition or well-being is likely to improve without the treatment
- whether the benefit the incapable person is expected to obtain from the treatment outweighs the risks of harm to him/her
- whether a less restrictive treatment would be as beneficial as the proposed treatment

Capacity: a person is capable with respect to a treatment if the person is able to understand the information relevant to making a decision about the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision

Consent: must be informed, must relate to the treatment, must be given voluntarily and must not be obtained through misrepresentation or fraud

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

Emergency: an emergency exists if the person is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm

Guardian of the Person: a decision maker through a power of attorney appointed by the office of the Public Guardian and Trustee (PGT) or through a court appointment, under the Substitute Decisions Act, 1992.

Informed Consent: consent is informed if, before giving it, the person has received information that a reasonable person in the same circumstances would require in order to make a decision about the treatment, as well as responses to requests for additional information, including information about the nature, benefits, material risks and side effects of the treatment, alternative courses of action, and the likely consequences of not having the treatment

Partner: either of two persons who have lived together for at least one year and have a close personal relationship that is of primary importance in both persons' lives

Plan of Treatment: a plan that is developed by one or more health practitioners, deals with one or more health problems of a person (and may, in addition, deal with health problems the person is likely to have in the future), and provides for the administration 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

Relative: a person related by blood, marriage or adoption

Spouse: two persons are spouses under the Act if they are married to each other or are living in a conjugal relationship outside marriage and have cohabited for at least one year, are together the parents of a child, or have entered into a cohabitation agreement under the Family Law Act

Substitute Decision Maker: a person who is authorized to give or refuse consent to a treatment on behalf of a person who is incapable with respect to the treatment

Treatment: anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, including a course of treatment or plan of treatment or community treatment plan; does not include assessment of capacity or general nature of a person's condition, the taking of a person's health history, the communication of an assessment or diagnosis, the admission of a person to a hospital or other facility (with some exceptions), a personal assistance service, or a treatment that in the circumstances poses little or no risk of harm to the person

References

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- College of Physiotherapists of Ontario. Code of Ethics.
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- Queens Printer for Ontario. Health Care Consent Act, 1996
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