COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

PRACTICE STANDARD

Consent to Treatment

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Related topic(s):	Consent of "Minors": Infants Act; Health Care (Consent) and Care Facility (Admission) Act; Photographic, Video and Audio Recording of Patients; Physical Examinations and Procedures; Medical Assistance in Dying; Indigenous Cultural Safety, Cultural Humility and Anti-racism; Consent to Treatment Equity Considerations Registrant Resource

A **practice standard** reflects the minimum standard of professional behaviour and ethical conduct on a specific topic or issue expected by the College of its registrants (all physicians and surgeons who practise medicine in British Columbia). Standards also reflect relevant legal requirements and are enforceable under the *Health Professions Act*, RSBC 1996, c.183 (*HPA*) and College Bylaws under the *HPA*.

Preamble

This document is a practice standard of the Board of the College of Physicians and Surgeons of British Columbia.

Definitions

informed consent	The patient must have been given an adequate explanation about the nature of the proposed investigation or treatment and its anticipated outcome as well as the significant risks involved and alternatives available to be able to reach an informed decision about the proposed treatment or procedure. In situations where the patient is not capable, the discussion must take place with the substitute decision-maker.[1]
treatment	Anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic, or other health-related purpose, and includes a course of treatment, plan of treatment, or community treatment plan.[2]
implied consent	Means consent that can be inferred by the patient's actions.[3]
express consent	Means consent which is expressed by a patient, either verbally or in writing. [3]
capacity to consent	Where an individual is able to understand the nature and anticipated effect of the proposed treatment and alternatives, and to appreciate the consequences of refusing treatment. Capacity to consent to a treatment can change over time and varies according to the individual patient and the complexity of the specific treatment decision. [1]
substitute decision-maker (SDM)	A person who may give or refuse consent to a treatment on behalf of an incapable patient. [2]
emergency	A situation where it is necessary to provide the health care without delay in order to preserve the adult's life, to prevent serious physical or mental harm or to alleviate severe pain.[4]

1 CMPA - Consent: A guide for Canadian physicians (cmpa-acpm.ca)
2 https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Consent-to-Treatment
3 CSHBC-SOP-PRAC-06-Client-Consent.pdf
4 Health Care (Consent) and Care Facility (Admission) Act (gov.bc.ca)

College's position

The obligation to ensure that valid consent is obtained always rests with the registrant proposing the treatment. For consent to treatment to be considered valid, it must be an "informed" consent.

While consent can be either expressed or implied, registrants are strongly advised to obtain express consent, when the treatment is likely to be more than mildly painful, carries appreciable risk or will result in ablation of a bodily function. Registrants affiliated with an institution (e.g. health authority, non-hospital medical and surgical facilities) must be aware of and comply with relevant consent policies and know when written consent is required. Consent for Medical Assistance in Dying (MAiD) must be obtained in accordance with the Medical Assistance in Dying practice standard and related legislation. Registrants may choose to use consent forms in other circumstances.

Registrants must always obtain express patient consent before proceeding with a sensitive physical examination or procedure, which includes clearly explaining the rationale for the physical examination or procedure and what it will involve. Registrants must stop the physical examination or procedure upon the patient's request, or if there are any obvious non-verbal cues of discomfort. Registrants should explicitly seek consent throughout the exam.

The College expects registrants to hold consent discussions with patients through an equity and inclusion framework, which considers an individual's unique needs, circumstances and lived experiences and may require alternate approaches for delivering information and obtaining consent. How a registrant obtains informed consent will differ with each patient and should always be viewed as evolving process, rather than a point-in-time decision.

In all circumstances, registrants must

- be aware of, and comply with, all of the requirements in the *Health Care (Consent) and Care Facility (Admission) Act* (*HCCFA*),
- not provide the treatment until they are assured that valid consent has been obtained,
- take reasonable steps to ensure the patient understands the information provided to them; consider and address language and/or communication issues that may impede a patient's ability to give valid consent,
- respect the decision of patients and substitute decision-makers (SDMs), who have the legal right to refuse, withhold, or withdraw consent to a treatment,
- be assured that, if delegating the act of obtaining consent to another health-care provider, such as a resident or fellow, the health-care provider has the knowledge, skill, and judgment required to obtain consent, and
- obtain independent legal advice or contact the CMPA if unsure of their legal obligations in specific circumstances.

Obtaining consent

As outlined in the *HCCFA* (section 6), for consent to be valid, registrants must ensure that it

- relates to the specific treatment being proposed,

- is given voluntarily and not under duress or coercion,
- is not obtained through misrepresentation or fraud,
    - registrants must be frank and honest when interacting with patients, including when conveying information about the proposed treatment
- is obtained from the patient, if they are capable with respect to consent to treatment, or from the patient's SDM, if the patient is incapable with respect to consent to treatment,
- is provided after information has been provided that a reasonable adult would require to understand the proposed health care and to make a decision, including information about
    - the condition for which the health care is proposed,
    - the nature of the proposed health care,
    - the risks and benefits of the proposed health care, and
    - alternative courses of health care, and
- is provided after an opportunity has been given for the patient or SDM to ask questions and receive answers about the proposed health care.

Capacity to consent

Registrants have a duty to take reasonable steps to be satisfied that their patients have understood the appropriate information, particularly when there may be language difficulties, emotional issues, questions of mental function, or a history of trauma. Registrants are entitled to presume capacity unless there are reasonable grounds to believe otherwise (e.g. something in a patient's history or behaviour raises questions about their capacity to consent to the treatment). Registrants must consider the patient's capacity at various points in time and in relation to the specific treatment being proposed. When making a decision about whether an adult is incapable of giving, refusing, or revoking consent to health care, a registrant must base the decision on whether the adult demonstrates that they understand the information given by the registrant and that the information applies to the situation of the adult for whom the health care is proposed.

Incapable patients and temporary substitute decision-making (TSDM)

The *HCCFA* (section 16) sets out a hierarchy of people who may give or refuse consent on behalf of an incapable adult, as well as additional requirements that must be met in order for an adult to be eligible to act as TSDM.

Where a patient is incapable of providing consent to treatment, registrants must obtain consent in accordance with section 16 of the *HCCFA*. In identifying a TSDM, registrants must take reasonable steps to ensure that the individual is the highest-ranking adult that satisfies the requirements for substitute decision-making under the *HCCFA*. In doing so, registrants 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. Even when patients are deemed incapable, the patient should be included in the consent discussions whenever reasonable. When possible, TSDMS have the duty to consult with the patient about their wishes.

Minors

The criterion for capacity to consent is maturity, not chronological age. With the exception of requests for MAiD, a minor is considered capable of consenting or refusing treatment (i.e. a **mature minor**) if the physical, mental, and emotional development of the minor will allow for a full appreciation of the nature and consequences of the decision.[5] The age in which a patient is capable of consenting depends on the extent of the proposed treatment, as well as the individual themselves. This means a minor may have the capacity to make certain decisions but not others. Where a registrant determines that the minor has the capacity, the registrant must obtain consent from the minor, even when accompanied by a parent or legal guardian. When a minor is not capable of consenting, a parent or guardian must provide consent and is required to act in the best interests of the minor.

Registrants can find further guidance on obtaining consent from minors in the College's *Consent of "Minors": Infants Act* legislative guidance document.

Documenting consent

Registrants must document in the patient's record information regarding consent to treatment where 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. It is strongly advised that registrants document consent in the patient's record in all other circumstances.

Registrants 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. Registrants are advised to record:

- the date of the dialogue(s) regarding consent;
- 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;
- the date that consent was given or refused; and
- any findings of incapacity and the identity of the TSDM, as necessary

Emergency treatment

Registrants must obtain consent from a patient before any treatment is administered except in cases of medical emergency when the patient (or substitute decision-maker) is unable to consent. For registrants to declare any clinical situation an emergency for which consent is not required, there must be demonstrable severe suffering or an imminent threat to the life of the patient.

Further, under medical emergency situations, treatments must be limited to those necessary to prevent prolonged suffering or to deal with imminent threats to life, limb or health. Even when unable to communicate in medical emergency situations, the known wishes of the

5 CMPA - Physician-Patient | Informed consent | CMPA Good practices (cmpa-acpm.ca)

patient must be respected. Registrants must also confirm with a second health care provider, where practicable, the need for emergency care and the incapability of the patient, as set out in section 12(1)(d) of the *HCCFA*.

Therefore, before proceeding, registrants must be satisfied there has been no indication in the past by way of advance directive or otherwise that the patient does not want the proposed treatment. Further, as soon as the patient is able to make decisions and regains the ability to give consent, a proper and "informed" consent must then be obtained from the patient for additional treatment.[6]

Involuntary admissions under the *Mental Health Act*

Treatment as described by the *HCCFA* does not include psychiatric treatment under the *Mental Health Act* (*MHA*).

The *MHA* provides that the director of a designated facility or the director's delegate may authorize **psychiatric** treatment for involuntary patients who are incapable of consenting or refuse to consent. Consent for treatment of involuntary patients must be obtained in writing by filling out and signing a Form 5 and including it in the patient's health record. Registrants are expected to follow the *MHA* and all applicable institution policy regarding mental health treatment.

The above applies only to psychiatric treatment. The *HCCFA* continues to apply to patient's admitted under the *MHA* for non-psychiatric treatment.

References

College of Physicians and Surgeons of Ontario. Consent to Treatment. Retrieved from: https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Consent-to-Treatment

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Canadian Medical Protective Association. Informed Consent: Good Practices Guide. Retrieved from: https://www.cmpa-acpm.ca/en/education-events/good-practices/physician-patient/informed-consent

6 CMPA - Consent: A guide for Canadian physicians (cmpa-acpm.ca)