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Consent and Treatment Capacity

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TREATMENT CAPACITY
TREATMENT UNDER THE HEALTH CARE CONSENT ACT, 1996

- Treatment means "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"

- are stated exceptions including:
  - → capacity assessments
  - → taking of a health history
  - → personal assistance service
  - → "a treatment that in the circumstances poses little or no risk of harm to the person"
  - → anything deemed not treatment by regulation

(HCCA, 1996, s. 2(1))

BASIC PRINCIPLE FOR TREATING AN INDIVIDUAL

Unless there is a legitimate "emergency"

- the capable person must consent to/refuse the treatment proposed

- the incapable person's valid substitute decision-maker must consent to/refuse the treatment proposed

(HCCA, 1996, s. 10)

- Capacity is the starting point: from whom is the health practitioner taking instructions?

HEALTH CARE CONSENT ACT, 1996

s. 10(1) **No treatment without consent** - A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

(a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or

(b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act.

HEALTH CARE CONSENT ACT, 1996

HCCA defines "capacity" in Section 4:

1) **Capacity** - A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

2) **Presumption of capacity** - A person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services.

3) **Exception** - A person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment, the admission or the personal assistance service, as the case may be."

HEALTH CARE CONSENT ACT, 1996

s. 15 **Capacity depends on treatment** - A person may be incapable with respect to some treatments and capable with respect to others.

s. 15(2) **Capacity depends on time** – A person may be incapable with respect to a treatment at one time and capable with respect to that treatment at another time

s. 16 **Return of capacity** - If, after consent to a treatment is given or refused on a person's behalf in accordance with this Act, the person becomes capable with respect to the treatment in the opinion of the health practitioner, the person's own decision to give or refuse consent to the treatment governs.

Judicial Interpretation of Treatment Capacity

SCC decision - Fleming v Starson 2003 SCC 32

Starson as enunciated by SCC is the highest authority in Ontario

Principles enunciated

1. Relevant information includes:
   - nature/purpose of treatment proposed
   - *condition diagnosed
   - expected benefits
   - material risks/side effects
   - alternative courses of action
   - likely consequence of no treatment
   - opportunity to have questions answered

Judicial Interpretation of Treatment Capacity

Principles enunciated (cont'd)

2. First branch of the capacity test as defined by Starson means:
   - the cognitive ability to process, retain and understand the relevant information

3. Second branch of the capacity test as defined by Starson means:
   - able to apply the relevant information to one's own circumstances
   - able to weigh the reasonably foreseeable risks and benefits of a decision

Judicial Interpretation of Treatment Capacity

- to be able to apply relevant information to one's own circumstances does not require person to agree with the diagnosis or to describe his mental condition as an "illness" or in otherwise negative terms

- if it is demonstrated that person has a mental 'condition', person must be able to recognize the possibility he is affected by the manifestations of that condition in order to be able to apply the relevant information to his own circumstances

- The focus of the test is on "ability" to understand/appreciate as opposed to "actual" understanding or appreciation, particularly given that actual understanding is impacted by quality and quantity of information provided by the health practitioner proposing treatment.

- Capacity is a two part, conjunctive test. To be capable one must be able to BOTH understand the relevant information and appreciate the reasonably foreseeable consequences of a decision.

CONSIDERATION OF CAPACITY IS NECESSARILY REQUIRED TO DETERMINE FROM WHOM THE HEALTH PRACTITIONER IS TO SEEK INSTRUCTIONS

- Capacity is presumed both at common law under the Health Care Consent Act, 1996 (section 4(2))
- If reasonable grounds to doubt someone's capacity, the assessment is required; otherwise one can rely on the presumption of capacity (section 4(3))
- This is also the logical interpretation of section 10(1) of the Act

CAPACITY: A PRACTICAL PARADIGM

- assessment of capacity with an exercise of professional judgment
- presume capacity unless reasonable to believe otherwise
- **do not presume treatment incapacity based solely on:**
  - → psychiatric/neurological disorder
  - → disability
  - → refusal to accede to practitioner's advice
  - → request for alternatives
  - → age
- **circumstances which may give rise to reasonable belief of incapacity:**
  - → confused/delusional thinking
  - → severe pain/fear/anxiety
  - → severe depression
  - → impairment - drugs/alcohol
  - → other observations
  - → inability to make settled choice

A PRACTICAL PARADIGM (cont.)

- if practitioner believes a person may be incapable, consider if person is able to understand relevant information regarding:
  - → condition
  - → nature/purpose proposed treatment
  - → risks and benefits of treatment
  - → alternatives - including no treatment

- if can understand relevant treatment information, consider following re: ability to "appreciate" consequences:
  - → condition that may affect the patient
  - → can assess how treatment/alternatives could affect quality of life
  - → decision cannot be based substantially on delusion

WHEN A HEALTH PRACTITIONER FINDS SOMEONE INCAPABLE WITH RESPECT TO A TREATMENT

CPSO has developed a policy guideline (February 2006) for assisting physicians in their discussions with incapable persons when emergency provisions do not apply:

- tell incapable person that SDM will help him/her understand the proposed treatment and be responsible for the final decision
- involve the incapable person (as much as possible) in discussions with SDM
- if person disagrees with need for SDM, or disagrees with involvement of present SDM, physician must advise person of options, including Consent and Capacity Board
- expected to help person exercise options

WHERE INCAPABLE WITH RESPECT TO TREATMENT OF A MENTAL DISORDER AND IN A SCHEDULED FACILITY UNDER THE MENTAL HEALTH ACT:

Regulation 741, section 15

- if person is at least age 14;
- admitted to a psychiatric facility
- incapable with respect to a treatment for mental disorder
- the attending physician must ensure that the person "promptly" receives written notice of the incapacity finding (Form 33)
- that a rights advisor is also "promptly" notified
- can result in Consent and Capacity Board application (and appeals)

Note: there are exceptions to the requirement to provide a Form 33:

- re: guardian of the person
- re: power of attorney for personal care
- if person unconscious/semi-conscious/unable to communicate comprehensibly
- if "emergency" as per s. 25 HCCA

ELEMENTS OF INFORMED CONSENT

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

(HCCA, 1996, s. 11(1))

- this essentially codifies the common law

WHEN IS CONSENT INFORMED?

Before consent given, patient has received information about:

- nature of treatment
- expected benefits
- material risks
- material side effects
- alternative courses of action
- likely consequences of not having treatment, and
- received answers to any requests for additional information

(HCCA, 1996, S. 11(2), (3))

NATURE OF CONSENT

- may be written or verbal
- may be express or implied (HCCA, s. 11(4))
- chart consent for health practitioner's protection

* A form of consent that sets out the legally required principles of substitute decision-making is useful evidence if issue of the "nature" of the consent granted, arises (e.g. where Board reviews CTO criteria, s. 33.1(4)(f) MHA)

INCLUDED CONSENT (HCCA s. 12)

- Where reasonable in the circumstances can presume that consent to a treatment includes consent to "variations or adjustments" in the treatment if the benefits/risks/side effects of the changed treatment are not significantly different
- Where reasonable in the circumstances, can presume that consent to treatment includes consent to continue the treatment in a different setting so long as no significant change in benefits/risks/side effects as a result

WHO CAN BE A LAWFUL SUBSTITUTE DECISION-MAKER ("SDM")

PART I - BASIC CRITERIA FOR ALL SDM

- SDM must be capable with respect to the treatment
- at least age 16 (unless SDM is parent of patient)
- available
- willing to assume the responsibility
- not prohibited by court order

(HCCA, 1996, s. 20(2))

WHO CAN BE A SDM?

PART II - THE LIST

- List appears in hierarchical order
- Public Guardian & Trustee (PGT) is SDM of last resort and "tie-breaker"

List:

– guardian of the person (with requisite authority)
– attorney for person care (with requisite authority)
– board appointed representative
– spouse or partner
– child or parent/C.A.S.
– parent with access rights only
– sibling
– any other relative (blood/marriage/adoption)
– PGT

(HCCA, 1996, s. 20)

PRINCIPLES FOR SUBSTITUTE DECISION-MAKING

PART I: PRIOR CAPABLE WISHES

- SDM is bound by applicable wishes expressed when patient was: capable; age 16 or greater
- such wishes may be oral, written in any form
- latest capable wishes prevail

(HCCA, 1996, s. 21(1); s. 5)

PRINCIPLES FOR SUBSTITUTE DECISION-MAKING

PART II - BEST INTERESTS

- Where no known applicable prior wishes, SDM must act in patient's "best interests"

- "Best interests" requires consideration of:

  - value/beliefs of person (when capable)
  - any treatment wishes that are not binding (i.e. incapable wishes)
  - whether treatment is likely to:
    - → improve condition
    - → prevent deterioration
    - → reduce rate of deterioration
  - person's condition absent the treatment
  - whether benefits outweigh risks
  - whether less restrictive/intrusive options are equally beneficial

(HCCA, 1996, s. 21(2))

- There is no indication in the statute how to weigh the various criteria SDM must consider

JUDICIAL INTERPRETATION OF SECTION 10(1)(b),

HEALTH CARE CONSENT ACT, 1996

s. 10(1)(b) has been interpreted as imposing a statutory obligation on health practitioners to ensure that substitute decision-makers understand the principles that inform their decision-making: the criteria in section 21 of the *Act.*

A.M. v. Benes; A.M. v. Attorney General of Ontario, Court of Appeal, November 10, 1999

CAPACITY TO DISCLOSE INFORMATION
(PHIPA s. 21)

- Person is capable of consenting to collection, use or disclosure of personal health information if the person is:
  - Able to understand information relevant to deciding whether to consent

    and
  - Able to appreciate the reasonably foreseeable consequences of giving, not giving, withholding, or withdrawing consent
- Capacity is presumed

CAPACITY IS INFORMATION SPECIFIC

- Can be capable of consenting to collection/use/disclosure of some parts of personal health information, but incapable with respect to others

CAPACITY CAN FLUCTUATE WITH TIME

- Can be capable of consenting to collection/use/disclosure at one time, but not capable at another

FORMS OF CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

- No one standard, required form (as in prior Form 14 under the Mental Health Act)

TYPICAL ELEMENTS OF A CONSENT FORM FOR RELEASE OF PERSONAL HEALTH INFORMATION

- Identifies subject of record (name/dob/health record no./address)
- Identifies what is the person/agency who holds records and who is being authorized to release information
- Identifies to whom the holder of the record is directed to release information
- May identify what type of information being released:
  - Medication summary
  - Discharge summary
  - Psychiatric progress notes
  - Admission history
  - "other"
- May identify the purpose of the release
- Form must be signed, dated
- If person releasing is not the subject, defines the relationship between the two
- Haveform witnessed
- May contain a statement that the consent may be withdrawn – in writing

CONSENT TO FURTHER RELEASE OF INFORMATION

- Released documents frequently come stamped with statement or accompanied by letter stating recipient cannot disclose further, or purporting to limit the use/further disclosure
- In my view, not necessarily legally binding on recipient unless these provisions placed on release by the capable person authorizing release