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CONSENT, CAPACITY TO CONSENT AND SUBSTITUTE CONSENT UNDER THE *SUBSTITUTE DECISIONS ACT, 1996*

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9:00 a.m. – 12:00 noon

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INTRODUCTION

(1) The Changing Legal Environment.
(2) The Courts' Expectations.
(3) Personal v. Vicarious Liability.
(4) Professional Accountability.

PART I: CONSENT

(1) The Issue of Consent Arises in Numerous Contexts.
   (a) Identify the specific consent issue in question - who is giving consent to whom for what?
   (b) The legal principles governing consent vary with the context.

(2) The Scope and Structure of the *Health Care Consent Act, 1996*, (*HCCA*).

1. To what and to whom does the Act apply?
   (a) Part II of the Act applies to "treatment," which is defined broadly as "anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment or plan of treatment." (s. 2)
   (b) However, the term "treatment" is defined as specifically excluding: capacity assessments; any treatment that poses little or no risk; examinations to determine the patient's general condition; taking a history; admission to a hospital, psychiatric, care, or other facility; and personal assistance services (i.e. feeding, washing, dressing, hygiene, and other routine activities of daily living). (s. 2)
   (c) Part II applies to regulated health practitioners (i.e. doctors, nurses, dentists, psychologists, etc.), but not to social workers, addictions counsellors, EAP workers, and youth workers. (s. 2)
   (d) Part II contains additional provisions governing substitute consent to general and emergency admission to hospitals and psychiatric facilities.
   (e) Part III of the Act governs substitute consent to admission and crisis admission to "care facilities" (i.e. nursing and old-age homes).
   (f) Part IV governs substitute consent to "personal assistance services."

2. The Act does <u>not</u> affect, among other things, the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or others. (s. 7)

(3) The General Principles of Consent under the *Healthcare Consent Act, 1996* (*HCCA*).

1. A health practitioner shall not administer treatment unless:
   (a) he or she is of the opinion that the patient is capable and has consented; or
   (b) he or she is of the opinion that the patient is incapable and the patient's substitute decision-maker has given consent in compliance with the *Act*. (s. 10)

2. Elements of a valid consent. (s. 11)
   (a) Consent must relate to the proposed treatment.
   (b) Patient must be adequately informed prior to consenting.
   (c) Consent is informed if the person consenting has received information about:
      • its expected benefits;
      • its material risks and side effects;
      • alternative courses of action;
      • the likely consequences of not having the treatment; and
      • the practitioner has answered the person's questions.
   (d) Consent must not be obtained by misrepresentation or fraud.
   (e) Consent may be given expressly or implicitly.
   (f) Consent must be given voluntarily.

3. Consent to treatment includes consent to variations or adjustments in treatment that pose similar risks and benefits. It also includes consent to the same treatment in a different setting (s 12).

4. Consent obtained by one health professional to a treatment plan constitutes valid consent to the other practitioners who are providing treatments that are included in the plan (s 13).

5. If a patient is capable, he or she may withdraw consent at any time. If a patient is incapable, his or her substitute decision maker may withdraw consent (s 14).

(4) The Common Law Principles of Consent Apply to Decisions Not Governed by Statute.

(a) The common law governs a competent patient's decision to enter or leave a care facility, to consent to personal assistance services, or to any care, counselling or service provided by a non-regulated health professional.

(b) The General Principles of Consent under the Common Law.

1. Generally, a counsellor must obtain a client's consent to initiate any test, procedure or counselling. A practitioner's mistaken belief that the client consented, when he or she has not consented, provides no defence.

2. The consent should be obtained in advance and cover not only the intervention, but also any related issues regarding record keeping, reporting and other disclosures of information.

3. The consent must relate to the specific treatment or counselling that is undertaken.

4. If a client is competent to give a valid consent, then it is his or her consent alone that is required.

5. The consent of next-of-kin is only relevant if a client is incapable of consenting.

6. To be valid, consent must be given "voluntarily," in the sense that the client's decision is the product of his or her conscious mind.

7. The consent must be based on a full and frank disclosure of the nature of the intervention and its risks.

8. A client may consent implicitly or explicitly. The fact that a client comes for treatment or counselling provides a broad measure of implied consent.

9. Clients may seek treatment, and yet expressly limit the scope of their consent.

10. If the conditions imposed by a client would render the treatment futile or harmful, a counsellor should withdraw from the treatment relationship. However, a counsellor cannot ignore a client's express prohibitions and override them.

(5) Exception to the General Common Law Principles.

(a) Emergency.

(b) Pre-existing general consent.

(c) Therapeutic privilege to withhold information.

(6) Consent Forms for Treatment.

(a) Preliminary issues.

(i) Do I need a signed consent form?

(ii) Who should get the client's consent and do I need a witness?

(iii) Consent to treatment versus documenting consent.

(iv) Consent to treatment versus a waiver of liability.

(b) Essentials of a valid consent form.
   (i) Identify the specific treatment, and explain its risks, benefits, side effects, and alternatives.
   (ii) Ensure that the consent form is consistent with the oral explanation.
   (iii) Ensure the language is readily understandable to the client.
   (iv) Clearly identify the document as a consent to treatment form and not a formality.
   (v) Give the client an opportunity to read the form and ask questions.
   (vi) Ensure the client can read English and comprehend the form's importance.

PART II: CAPACTIY (COMPETENCY) TO CONSENT

(1) The Issue of Capacity Arises in Numerous Contexts.
   (a) Identify the specific capacity issue in question - who is capable of consenting to what?
   (b) The legal principles governing capacity vary with the context.

(2) Capacity to Consent under the *HCCA.*
   (a) A person is capable if he or she is able to understand the information relevant to making an informed decision, and is able to appreciate the reasonably foreseeable consequences of the decision. (s. 4)
   (b) A person's capacity concerning the same treatment may change over time. (s. 15(2))
   (c) If a person regains capacity, it is his or her decision that governs and not that of the substitute decision-maker. (s. 16)
   (d) A person may be capable of consenting to some treatments, but not others. (s. 15(1))
   (e) A person is presumed to be capable with respect to treatment, admission to a care facility, and personal assistance services. A person is entitled to rely on the presumption, unless he or she has reasonable grounds to believe otherwise. (s. 4(2) and (3))

(3) Statutory Ages of Consent to Treatment, Care and Counselling.
   (a) There is no general age of consent to treatment, care and counselling in Ontario.
   (b) There are some narrowly-defined statutory ages of consent under specific statutes:
      (i) *Child and Family Services Act.*
      (ii) *Education Act.*
      (iii) *Trillium Gift of Life Network Act.*

(4) Competency to Consent Cases.
   • *C v Wren* (1986), 35 DLR (4th) 419 (Alta CA).

C, a pregnant 16-year-old girl, abruptly left home and made arrangements for an abortion. Her parents, morally opposed to the abortion, sought to prevent the procedure by challenging C's capacity to consent. The Court sympathized with both the parents and their daughter in this painful dispute. Nonetheless, the legal issue was clear – could this 16-year-old girl give a valid consent to a therapeutic abortion? The Court concluded that C understood the nature of the procedure and its risks. Consequently, she was competent to give a valid consent and her parents' wishes were not relevant. The Court stated that the parental right to make treatment decisions for a child terminates if and when the child achieves a sufficient understanding and intelligence to fully comprehend the proposed treatment.

- *Thompson v Grant*, [2005] OJ No 36 (QL) (Sup Ct J), aff'd (2005), 15 ETR (3d) 311 (CA).

The appellant, who suffered from paranoid schizophrenia, refused to take her medication because of its "unbearable" side effects. Her substitute decision maker, her healthcare practitioner and her caregiver believed that her refusal to take the medication substantially aggravated her condition and caused her to be delusional. Her doctor concluded that she was not competent to consent or refuse consent to the medication. The appellant challenged the doctor's assessment, but it was affirmed by the Consent and Capacity Board.

While the Board found that the appellant satisfied the first part of the capacity test set out in section 4(1) of the *HCCA*, in that she understood the information relevant to making a decision about her medication, she did not meet the second part of the test. Based on the medical evidence, the Board found that she was unable to appreciate the reasonably foreseeable consequences of her decision. Consequently, the Board held that the appellant was incapable of refusing consent to the medication.

The appellant appealed the Board's decision to the Superior Court of Justice pursuant to s 80(1) of the *HCCA*. The Court noted that the standard of review in an appeal of a factual nature is that of reasonableness. Having found the Board's decision to be reasonable, the Court dismissed the appeal and upheld the Board's finding that the appellant was incapable of refusing consent to the medication.

(5) A Patient's Rights under the *HCCA* on Being Found Incapable.

(a) In accordance with the guidelines established by their governing bodies, health practitioners who find a patient to be incapable must provide information on the consequences of that finding to the patient. (s. 17)

(b) A patient who is found to be incapable may apply to the Consent and Capacity Board to review the practitioner's finding of incapacity. This provision does not apply to a patient who has a "guardian of the person" with authority to consent or refuse consent to treatment.

(c) The Board may confirm or reject the health practitioner's finding that a patient is incapable. (s. 32(4))

(d) Except in specified circumstances, no treatment can be performed on an incapable patient if he or she has applied to the Board to review the finding of incapacity or to appoint a representative. (s. 18(1)-(3))

(e) A person 16 years of age or older, who is not capable of consenting to treatment, personal assistance services or admission to a personal care facility, may apply to the Board to appoint a representative to give or refuse consent on his or her behalf, if the person does not already have a guardian or an attorney for personal care appointed under the *Substitute Decisions Act, 1992*.

Individuals may also apply to the Board to be named an incapable person's personal representative. The Board may appoint the person named by the patient, or may appoint another person as representative, unless the patient objects to that other person. (*HCCA*, ss. 33, 51 and 66)

(6) Advance Directives (Prior Expressed Wishes, and Living Wills) under the *HCCA*.

(a) Competent individuals who are 16 years of age or older can make binding directives concerning their future treatment, personal assistance services, or admission to hospital, psychiatric and care facilities.

(b) These directives may be communicated orally or in writing. Later directives prevail over earlier directives. (s. 5)

(c) No written or other formal proof is necessary in terms of whether the directive was made. Since the *HCCA* presumes that everyone is capable, no proof is required that the person was capable when the directive was made.

(7) Competency to Manage Property under the *Substitute Decisions Act* (*SDA*).

A person is capable of managing property if he or she is able to understand the information relevant to making a decision, and able to appreciate the reasonably foreseeable consequences of a decision. (s. 6)

PART III: SUBSTITUTE CONSENT

(1) Substitute Consent under the *HCCA*.

1. A substitute decision-maker must (s. 21(1)):
   (a) give or refuse consent in accordance with the known wishes expressed by the person while competent and over 16; or
   (b) if no prior wish is known or it is impossible to comply with the wish, base consent on the incapable person's best interests.

2. The following shall be taken into consideration when determining best interests (s 21(2)):
   (a) the values and beliefs that the incapable person held when he or she was competent;
   (b) any wishes expressed by the person while incapable or under 16;
   (c) whether the incapable person's condition or well-being is likely to improve or not deteriorate further with the treatment or without the treatment;
   (d) whether the benefits of the treatment outweigh the risks of harm to the patient; and
   (e) whether a less restrictive or intrusive treatment would be as beneficial as the proposed treatment.

3. Before giving or refusing consent, a substitute decision-maker is entitled to all the information necessary for making an informed decision. (s. 22(1)) This provision prevails despite anything to the contrary in the *Personal Health Information Protection Act, 2004*. (*HCCA*, s. 22(2))

4. If an incapable person is 16 years or older and objects to admission to a psychiatric facility, the substitute decision-maker can only consent to admission if he or she is:
   (a) the incapable person's appointed guardian and has been granted specific authority to consent to that admission; or
   (b) the incapable person's attorney for personal care and the power of attorney grants specific authority to consent to that admission. (s. 24(2))

5. A person who has authority to consent to treatment on an incapable person's behalf may consent to necessary and ancillary treatments and to admission to a hospital, psychiatric or other health facility. (ss. 23 and 24(1))

(2) Authority to Exercise Substitute Consent for Care and Treatment.

There are five ways in which a person may obtain authority to make substitute care and treatment decisions for another person.

(a) Any person may apply to become a court-appointed guardian of an incapable person. (*SDA*, s. 55)

(b) An attorney for personal care appointed by the person while competent, and 16 years of age or older. A person may name whoever they want to be their power of attorney, but that person must be available, willing and capable. If two or more persons are named and they disagree, the Public Guardian and Trustee must decide.

(c) The Consent and Capacity Board may appoint an individual designated by the incapable person or another individual to be the incapable person's personal representative to make decisions concerning treatment, personal assistance services and admission to care facilities. (*HCCA*, ss. 33(1), 51(1) and 66(1))

(d) Section 20 of the *HCCA* outlines a hierarchy of substitute decision-makers who may authorize treatment if a patient is incapable. Next in order after a court-appointed guardian of the person, power of attorney and personal representative are:
   (i) partner/spouse;
   (ii) custodial parent, guardian and child;
   (iii) parent with access;
   (iv) sibling; and
   (v) relative by blood, marriage or adoption.

(e) Public Guardian or Trustee.

(3) Safeguards on Substitute Decision-Making for Personal Care and Treatment.
   (a) A healthcare provider can apply to the Consent and Capacity Board if he or she believes that a substitute decision-maker did not act in accordance with the person's expressed wishes or in the incapable person's best interests as required by s. 21. If the Board concludes that s. 21 was not complied with, it may substitute its opinion for that of the substitute decision-maker. (*HCCA*, s. 37)
   (b) The PGT has a duty to investigate any allegation that a person who is incapable of personal care may be suffering or is at the risk of suffering serious illness or injury, or a deprivation of liberty or personal security. If the PGT has reasonable grounds to believe that the person is incapable and is suffering these "serious adverse effects," the PGT must apply to the court for an order appointing him or her as the incapable person's temporary guardian. (*SDA*, s. 62)
   (c) An application can be made to the court to resolve any question arising in a guardianship of the person or a power of attorney for personal care. The application may be made by the incapable person's guardian, attorney under a power of attorney for personal care, dependant, guardian of property, attorney under a continuing power of attorney, the PGT, or by any other person with leave of the court. The court may make any order it considers to be for the benefit of the incapable person that is consistent with the *Act*. (*SDA*, s. 68)

(4) Advanced Directives v. Powers of Attorney for Personal Care and Treatment.
   (a) Directives need not be written, witnessed or accompanied by any evidence that the grantor was competent when making the directive.
   (b) Directives govern care and treatment decisions, but not the person who exercises substitute consent.

(5) Substitute Decision-Making for Property.
   There are five ways in which a person may obtain authority to make substitute decisions regarding another person's property.
   (a) Power of attorney for property under the *Powers of Attorney Act*, R.S.O. 1990, c. P.20.
   (b) A person who is 18 years of age or older and competent may create a continuing power of attorney for property under sections 5 and 7(1) of the *SDA*. The document may be drafted to give the attorney authority to manage the grantor's financial affairs while the grantor is competent or may be written to come into effect only upon the grantor becoming incompetent.
   (c) If a patient in a psychiatric facility is certified under the *Mental Health Act* to be incapable of managing property, the PGT becomes the person's statutory guardian of property. (*SDA*, s.15) If a psychiatric patient has a valid power of attorney for property, that attorney will automatically replace the PGT. (*SDA*, s. 16.1)
      A person may request an assessor to assess his or her own capacity or that of another individual to determine if the PGT should become the person's statutory guardian of property. (*SDA*, s. 16(1))
   (d) An incapable person's spouse, partner or relative may apply to the PGT to replace the PGT as the incapable person's statutory guardian of property. (*SDA*, s. 17(1))
   (e) Any person, with some limited exceptions, may apply to a court to become an incapable person's court-appointed guardian of property. (*SDA*, ss. 22 and 24)

(6) Safeguards on Substitute Decision-Making for Property.
   (a) The PGT has a duty to investigate any allegation that a person who is incapable of managing property:
      (i) has lost, or may be at risk of losing, a significant portion of his or her property, or
      (ii) is failing, or may be at risk of failing, to provide necessities of life for him or herself, or his or her dependents. (*SDA*, s. 27(1) and (2))
   (b) If the PGT has reasonable grounds to believe that it is necessary to appoint a temporary guardian of property to prevent such "serious adverse effects," the PGT must apply to the court to be made a temporary guardian of the incapable person's property. (*Ibid*., s. 27(3.1))
   (c) The incapable person's guardian of the person, attorney under a continuing power of attorney, dependents, guardian of the person, attorney for personal care, the PGT, or any other person with the court's consent may apply to the court to resolve any question arising in a guardianship of property or a continuing power of attorney for property. The court may make any order it considers

to be for the benefit of the incapable person, or his or her dependents that is consistent with the *Act*. (*Ibid*., s. 29)

(7) Obligations of Guardians and Power of Attorneys for Property.

(a) A guardian of property is a fiduciary whose powers and duties shall be exercised diligently, with honesty and integrity, and in good faith, for the incapable person's benefit. A guardian must consider the effects that his or her decisions have on the incapable person's comfort and well-being. (*Ibid.*, s. 32(1))

(b) Financial decisions shall be made in a manner consistent with personal care decisions, unless doing so would have a disproportionately adverse effect on the incapable person's property. (*Ibid.*, s. 32(1.2) and (1.3))

(c) The guardian shall explain to the incapable person what a guardian's powers and duties are, and encourage the incapable person to participate to the extent possible. The guardian shall encourage regular personal contact between the incapable person and supportive family members and friends, and consult with such family and friends from time to time. (*Ibid*., s. 32(2)-(5))

(d) Section 37 sets out the principles governing the expenditures that can be made on the incapable person's behalf. Limits are put on gifts, loans and charitable donations.

(e) A guardian of property who is not compensated shall exercise the degree of care, diligence, and skill that a person of ordinary prudence would exercise in managing his or her own property. A guardian who is compensated shall exercise the degree of care, diligence and skill that a person in the business of managing the property of others is required to exercise. (*Ibid.*, s. 32(7) and (8))

(f) A guardian of property is liable for damages resulting from any breach of his or her duties. A court may relieve the guardian of all or part of this liability if he or she acted honestly, reasonably and diligently. (*Ibid.*, s. 33)

(g) A guardian of property must act in accordance with the management plan established for the property, and must keep proper accounts, as required by the regulations, for all transactions. (*Ibid*., s. 32(11) and (6))

(h) With the exception of the need to follow a management plan, these principles apply equally to an attorney under a continuing power of attorney if the grantor is, or there are reasonable grounds to believe that the grantor is, incapable of managing property. (*SDA*, s. 38(1))

(i) The PGT is required to maintain an updated register of guardians of the person and guardians of property. The register includes information on: how the guardian acquired his or her authority; any restrictions on the guardian's authority; and the date the guardian's authority took effect, terminated or was changed. (SDA, O. Reg. 99/96, s. 3(1))

The PGT is required to provide this information to anyone who requests it. (*Ibid.*, s. 6)

• *Penny v. Bolen*, [2008] O.J. No. 3734 (S.C.J.).

Three of the five children of B, who managed their mother's funds under a continuing power of attorney dated 1994, arranged for a capacity assessment of their mother. Before it was conducted, B executed a new will and power of attorney revoking the appointment of her children and appointing her brother G, as she had concerns about how her children were managing her money. She also obtained her own assessment stating that she was capable of managing her property, contrary to the assessment obtained by her children.

The Court held that B was mentally competent to execute the new power of attorney, a finding supported by the evidence of B's family physician, who stated that he had never seen any evidence that B was not mentally competent. Her solicitor also said she was clearly able to comprehend the effects of her last will and testament and powers of attorney. B's children were ordered to file and pass accounts for their dealings with all of B's funds.

PART IV: CONCLUSION