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Tip Sheet #1
Health Care Consent and Advance Care Planning
The Basics

What is HEALTH CARE CONSENT[1]?

- **Informed DECISIONS** about treatment, admission to long term care, and personal assistance services in long term care
- **Consent (a DECISION about health care**) is obtained **by the Health practitioner** from the **Patient,** before treatment commences, and after communication with the Patient about the Patient's condition, treatment options, and the risks, benefits, side effects, alternatives and what would happen if the Patient refused the treatment.
- **If the Patient is not mentally capable** to make the treatment decision then the same communication is with the **Patient's SUBSTITUTE DECISION MAKER**[2] (SDM)
- Consent INCLUDES planning about care (immediate care options but also setting goals for care and preparing plans of care[3] related to the Patients' present health condition)

What is ADVANCE CARE PLANNING[4]?

Advance Care Planning has TWO PARTS

- **FIRST – A Decision about Future SDM**

  DECISION about who would be the Patient's future SDM which is done either by:

  - Patient confirming he or she knows who is his or her **AUTOMATIC future Substitute Decision Maker in the hierarchy list**[5] that is in the *Health Care Consent Act* **(see Tip Sheet #2 for explanation of the Hierarchy List)** and that he or she is satisfied that that person should so act as SDM when the Patient is incapable OR

  - Patient choosing someone else to act as SDM by preparing a **Power of Attorney for Personal Care**[6] **(POAPC).**

- **SECOND – Patient communicating WISHES**[7]

  Making statements about wishes **for future care**, if the Patient has any, as well as the Patient expressing his/her own **values, beliefs and anything else that he/she thinks**

will help the Patient's SDM understand how to make decisions for the Patient when he/she is not mentally capable. The SDM needs to understand the Patient's wishes, values, beliefs to be able to make decisions as close to what the Patient, if he/ she was still capable, may have made if they had all the information to make an informed consent.

- **Wishes** may be in **WRITING** or may be expressed **ORALLY** or may be **communicated by any alternative means** that the Patients uses to communicate.

- **The one exception** to Advance Care Planning orally or by alternative means is the **appointment of an SDM**. To appoint someone as an Attorney, the Patient must sign a POAPC document. This part of Advance Care Planning must be done in writing.

- Advance care planning communications are **NOT CONSENTS** but are **WISHES**

- Even if any Advance Care Planning has been documented in any way, the Health practitioner MUST still get an informed consent from the Patient if capable or where the Patient is incapable, from the Patient's SDM. The Advance Care Planning wishes, values, beliefs of the patient may be used to **inform the conversation** about consent although it is not the final consent to any plan of treatment for the Patient

- **ONLY the PATIENT** when capable can do Advance Care Planning

- SDMs **CANNOT** do Advance Care Planning (either part of the two steps) but can **ONLY give or refuse consent to treatment** or make other health decisions for the incapable Patient.

- If there are any Advance Care Planning wishes communicated by the patient, whether written or oral or communicated by any other means, the **SDM must interpret the Patient's wishes** and must determine:
    - whether the wishes of the Patient were expressed when the Patient was still capable (and were expressed voluntarily);
    - whether the wishes are the last known capable wishes or whether the Patient changed his/her mind when still capable,[8]
    - **what the Patient meant in that wish;**
    - **whether it is POSSIBLE to follow the wish**
    - and whether the wishes are applicable to the particular decision at hand[9]

- If no such wishes are known, then SDM must decide what is in the "**best Interests**"[10] of the Patient, as defined in the *Health Care Consent Act*.

- SDMs **SHOULD** advise the Health practitioner of any known wishes the Patient may have expressed while competent that are applicable to the decision to be made when discussing treatment options.

- **WITHOLDING OR WITHDRAWING of Treatment** - If the Patient's present plan of treatment may 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, and may provide for the administration to the Patient of various treatments or courses of treatment. It may also provide for the withholding or withdrawal of treatment.

- The SDM **may CONSENT or REFUSE** consent to “future” treatments, such as No Resuscitation. The SDM is **NOT** Advance Care Planning but is giving or refusing consent because the SDM is making decisions **in context of the Patient’s present condition** and with the information required to provide an informed consent.

The HEALTH DECISIONS FRAMEWORK

Role of Health practitioner REQUIREMENT TO OBTAIN INFORMED CONSENT[11]

- Before providing any treatment to a Patient, **HEALTH PRACTITIONERS[12] have the legal and ethical duty to obtain INFORMED CONSENT from a Patient**, if the Patient is MENTALLY CAPABLE to make the decision about the particular treatment being offered[13]. If the Health practitioner is of the opinion that the Patient is not mentally capable to consent to the particular treatment[14] proposed, **then the Health practitioner must turn to the Patient’s SUBSTITUTE DECISION MAKER (SDM) who gives or refuses the informed consent on behalf of the Patient.**

- In an **EMERGENCY** where the patient is mentally incapable or cannot communicate,[15] **Health practitioners do not need to obtain Patient consent** in order to provide treatment but must **follow any known WISHES** of the Patient in respect to the treatment.

- Health practitioners may also encourage Patients to do Advance Care Planning (confirm or choose a future SDM and **encourage Patients to communicate** what quality of life means to them, any wishes about future care and their values, beliefs, **to that future SDM**)

PROCESS

- As part of most contacts with Patients, Health practitioners may proceed through the stages of the SOAP analysis.[16] **Obtaining Informed consent from the Patient is part of the “Plan” stage of this process.**

S	(Subjective) Patient’s/SDM’s description of the Patient’s health concerns, past medical history, review of medications, allergies, etc.
O	(Objective) Health practitioner’s observations including physician examination, positive and negative physical findings, laboratory and procedures results etc.
A	(Assessment) Health practitioner assessment or diagnosis of Patient’s condition.
P	(Plan) Health **practitioners proposes plan** for managing the Patient’s conditions including treatment options.

  - **Health practitioner discusses with the Patient/SDM** the Patient's health condition and the treatment options the Health practitioner is offering to the Patient. The Health practitioner must describe the risks, benefits, side effects of those treatment options, alternatives (if any) to the options, and what could happen if the Patient/SDM refuses the treatment offered (Informed Consent). The Health practitioner must also answer any questions the Patient/SDM may have about the Patient's condition and the treatment options.

  - **The final treatment plan is what the Patient/SDM has consented to.**

COMMUNICATION – BOTH FOR TREATMENT DECISIONS AND ADVANCE CARE PLANNING

- **Health practitioners need to communicate** with the Patient (or SDM) about
  - Treatment options, risks, benefits, side effects, alternatives and the consequences of refusing treatment;
  - Discussions about the Patient's wishes, values, beliefs, and what the Patient thinks of as quality of life, and
  - Discussions about the goals of care.

Role of the Patient – CONSENT and ADVANCE CARE PLANNING

- **A Patient, if mentally capable** for treatment decision-making, **is the decision-maker** and **must provide the INFORMED CONSENT.**

- A Patient may also expresses **WISHES** about future health treatment. **WISHES** about future health treatment are referred to as **Advance Care Planning.**

- Wishes may be in WRITING or may be expressed ORALLY or may be communicated by any alternative means that the Patient uses to communicate.

- A Patient, if MENTALLY INCAPABLE for treatment decision-making, may still express wishes regarding his/her treatment which must be taken into consideration by the SDM, **although the SDM is not bound by those wishes expressed after incapacity**

- Advance Care Planning in any form is **NOT** consent – wishes are **NOT** decisions. **Even if any form (oral, written , communicated by alternative means) of Advance Care Planning exists, the Health practitioner MUST still get an informed consent from the Patient if capable or the incapable patient's SDM.** Advance Care Planning wishes, values; beliefs may be used to inform the conversation about consent although it is not the final consent to any plan for the Patient.

Role of the Substitute Decision Maker (SDM) – CONSENT ON BEHALF OF A PATIENT, IF PATIENT IS INCAPABLE

- If the **Patient is not mentally capable**, then his or her **SDM, is the decision-maker** and provides INFORMED CONSENT to treatment for the Patient

- SDMs can only consent or refuse consent to treatments and **cannot do Advance Care Planning** (i.e. they cannot expresses wishes, values, and beliefs on behalf of the patient)

- SDMs must follow any wishes (ACPs) of a Patient, expressed when mentally capable, when making treatment decisions for the Patient if known, that are relevant to the decision to be made, and have not been changed by the Patient when still capable and are POSSIBLE to follow..

- **If no wishes are known, then the SDM makes decisions in the "best interests**" of the Patient.

- **"Best Interests**"[17] is defined in the *Health Care Consent Act*. If an SDM needs to determine what the "best interests" are for a Patient that is incapable, he /she must consider:

  a) values and beliefs that the SDM knows that the incapable person held when capable and believes that he or she would still act on

  b) other wishes of the incapable person with respect to treatment, admission, personal assistance services that are not required to be followed (i.e. those wishes expressed AFTER the person became incapable)

  c) whether treatment likely to:
     - improve the persons condition or well being
     - prevent condition or well being from deteriorating
     - reduce the extent or rate of deterioration of the persons condition or well being

  d) whether condition or well being is likely to improve or remain the same or deteriorate without the treatment

  e) if benefit outweighs risk of harm

  f) Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment proposed.

- If the Patient's present plan of treatment addresses one or more of the health problems that the Patient is likely to have in the future given the Patient's CURRENT health condition, and provides for the administration to the Patient of various treatments or courses of treatment, **then the SDM can CONSENT or REFUSE consent to these "future" treatments (such as No Resuscitation).** In these circumstances, **the SDM is not Advance Care Planning but is giving or refusing consent to a Plan of Care (as** the SDM is making decisions in the context of the Patient's present condition and with the information required to provide an informed consent).

ENDNOTES

[1] *Health Care Consent Act*, s.10, s.11 Requirement for an Informed Consent

[2] *Health Care Consent Act*, s 20 Hierarchy of SDMs and how Hierarchy works

ENDNOTES

[3] *Health Care Consent Act,* s13. Definition of Plan of Care

[4] *Health Care Consent Act, s 5 The* HCCA does not refer to “Advance Care Plans” or “Advance Directives” but refers to Wishes. Wishes may be expressed orally, in writing or be communicated by any other means.

[5] *Health Care Consent Act s20* Hierarchy of SDMs

[6] *Substitute Decision Act* , s.46 and HCCA, s20 Definition of POAPC and ranking of attorney in POAPC on HCCA Hierarchy

[7] *Health Care Consent Act*, s. 5 Wishes and How Wishes may be expressed

[8] *Health Care Consent Act* ,s.5 Later Wishes Prevail over earlier wishes

[9] *Health Care Consent Act*, s.21 Principles for Giving or Refusing Consent

[10] *Health Care Consent Act*, s. 21(2) Definition of Best Interests

[11] *Health Care Consent Act* , s10 and s. 11 Consent required and Informed Consent defined

[12] *Health Care Consent Act*, s.2. Definition of Health practitioner

[13] *Health Care Consent Act,*s.10 and s. 17 I Includes requirement for rights information if Health Practitioner of opinion that Patient is not mentally capable to give or refuse consent

[14] *Health Care Consent Act* s, 4 and s.15 Capacity defined and Capacity depends on Treatment and time

[15] *Health Care Consent* Act, s.25 Definition of emergency

[16] College and Physicians and Surgeons, Policy Statement #4-12 Medical Records, Last Reviewed and Updated May 2012

[17] *Health Care Consent* Act, s.21 (2) Definition of “Best Interests”.