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

What is HEALTH CARE CONSENT¹?

- 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 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 MAKER²
- Consent INCLUDES planning about care (immediate care options but also setting goals for care and preparing plans of care³ related to the Patients' present health condition)

What is ADVANCE CARE PLANNING⁴?

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 list⁵ that is in the *Health Care Consent Act* 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 Care⁶.

- **SECOND – Patient communicating WISHES⁷**

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 what he/she may want or not want in terms of health care when the Patient is not mentally capable and is not able to provide his/her own consent or refusal of consent to treatments and health care at the time such decisions need to be made

- Wishes (Advance Care Plans) 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 plans are **NOT CONSENTS** but are **WISHES**
- Even if an Advance Care Plan exists, 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 Plan may be used to **inform the conversation** about consent although it is not the final consent to any plan for the Patient
- **ONLY** the PATIENT when capable can Advance Care Plan
- SDMs **CANNOT** Advance Care Plan but can **ONLY** give or refuse consent to treatment or make other health decision for the incapable Patient.
- If there is any Advance Care Plan, 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;
 - and whether the wishes are applicable to the particular decision at hand⁹
- 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.
- **WITHHOLDING OR WITHDRAWING of Treatment** - If the Patient's present plan of treatment deals 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 provides 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 **can CONSENT or REFUSE** consent to these "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 CONSENT¹¹

- Before providing any treatment to a Patient, HEALTH PRACTITIONERS¹² 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 offered¹³. If the Health Practitioner is of the opinion that the Patient is not mentally capable to consent to the particular treatment¹⁴ 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 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 Advance Care Plan (confirm or choose a future SDM and **encourage Patients to communicate** any wishes about future care and their values, beliefs, approach to quality of life **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 treatment options the Health Practitioner is offering, 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 final 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 goals of care; and,
 - Discussions about the Patient's wishes, values, beliefs, and what the Patient thinks of as quality of life.

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 express **WISHES** about future health treatment. **WISHES** about future health treatment are referred to as **Advance Care Plans**
- 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 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
- An Advance Care Plan is **NOT** a consent – wishes are **NOT** decisions. Even if an Advance Care Plan exists, the health practitioner **MUST** still get an informed consent from the Patient if capable or the incapable patient's SDM. The Advance Care Plan 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 Advance Care Plan** (i.e. they cannot express wishes, values, and beliefs on behalf of the patient)
- SDMs must follow any wishes (ACPs) of a Patient 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.
- 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 (ie those wishes expressed AFTER the person became incapable)
 - c) whether treatment likely to:
 - d) improve the persons condition or well being
 - e) prevent condition or well being from deteriorating
 - f) reduce the extent or rate of deterioration of the persons condition or well being
 - g) whether condition or well being is likely to improve or remain the same or deteriorate without the treatment
 - h) if benefit outweighs risk of harm
 - i) 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” .