Standard of Practice S-013

Consent

Quality Assurance Committee
Approved: November 30, 2002
Amended: November 24, 2004,
September 20, 2013, February 23, 2016

Note to readers: In the event of any inconsistency between this document and the legislation that affects chiropractic practice, the legislation governs.

Intent

To advise members of their obligations relating to consent for examination, care and plans of care.

Objectives

- To clarify the consent requirements outlined in legislation, case law and CCO standards of practice, policies and guidelines as they relate to examinations, care and plans of care.
- To ensure patients receive appropriate information about the benefits and risks of examinations, care and plans of care.
- To facilitate discussion and dialogue between members and patients relating to chiropractic care.
- To ensure members and the public are aware of the mutual benefits of fully informed, voluntarily given consent to examinations, care and plans of care.

Description of Standard

Elements of Consent to Examination

A member is to obtain patient consent to an examination, including diagnostic imaging, from a patient or his/her substitute decision-maker (patient)[1], that is:

- fully informed;
- voluntarily given;
- related to the patient's condition and circumstances;
- not obtained through fraud or misrepresentations;
- obtained following a consultation and history taking, but prior to any physical examination or diagnostic testing of the patient; and
- evidenced in a written form signed by the patient or otherwise documented in the patient health record. It is sufficient to obtain verbal consent to examination from the patient and document this consent in the patient health record.

Elements of Consent to Care

A member is to obtain patient consent to care or to a plan of care, that is:

- fully informed;
- voluntarily given;
- related to the patient's condition and circumstances;
- not obtained through fraud or misrepresentations;
- obtained following the examination and report of findings, but before any chiropractic care is delivered; and
- evidenced in a written form signed by the patient or otherwise documented in the patient health record.

Implied Consent

In certain limited circumstances, consent to an examination, care or plan of care may be implied. However, the onus is on a member to substantiate that circumstances warranted a variation from the requirements for obtaining consent as outlined in this standard of practice.

Appropriate Discussion and Dialogue for Consent

In order to be "informed," consent to examination (including diagnostic imaging) care or a plan of care shall include a discussion of these items:

- What is the recommended examination, care or plan of care?
- Why should the patient have the examination or care or plan of care?
- What are the alternatives to the examination or care or plan of care?
- What are the effects, material risks and side effects of the proposed examination, care or plan of care and how they compare to the alternatives?
- What are the likely consequences if the patient does not have the examination, care or plan of care?

In discussing the effects, material risks and side effects of the proposed examination or treatment and alternative examinations or treatments, members shall disclose improbable risks particularly if the effects are serious. Accordingly, members shall include a discussion with patients of the rare but potentially serious risk of stroke associated with cervical adjustments.

During discussions, a member shall provide patients with an opportunity to ask questions concerning the proposed examination, care or plan of care and shall answer questions prior to the commencement of the examination or treatment.

A patient may withdraw his/her consent to any examination, care or plan of care at any time.

The standard of disclosure focuses on the patient and what a reasonable person in the patient's position would need to know to make an informed decision. A member is advised to err on the side of caution in providing comprehensive disclosure.

There is an expectation that a member fully informs the patient of the identity and professional status of any health care professional providing professional services, especially in, but not limited to, a multi-disciplinary practice or when a member assigns any part of an examination, care or plan of care to an assistant or another health care professional.

Consent to a New Examination and Consent to Care or Plan of Care

A member shall recognize that obtaining consent is an ongoing and evolving process involving continuous discussions with a patient and not a one-time event of a patient's signature on a consent form. If a member recommends a new examination, care or plan of care, there are significant changes in a patient's condition, or there are significant changes in the material risks to a patient, a member shall continue to dialogue with the patient. This discussion should be about the material risks, benefits and side-effects of the recommended examination, care or plan of care, including potential risks that may be of a special or unusual nature. A member shall make a notation of the discussion in the patient health record.

Emergency Care[23]

An emergency is defined in section 25(1) of the *HCCA* as follows: "there is an emergency if the person for whom the treatment is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm."

A member may provide care without consent to a person who is incapable with respect to the care, if, in the opinion of the member:

- there is an emergency; and
- the delay required to obtain a consent or refusal on the person's behalf will

prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm.

A member may provide care without consent to a person who is apparently capable with respect to the care, if, in the opinion of the member:

- there is an emergency;
- the communication required in order for the person to give or refuse consent to care cannot take place because of a language barrier or because the person has a disability that prevents the communication from taking place;
- steps that are reasonable in the circumstances have been taken to find a practical means of enabling the communication to take place, but no such means has been found;
- the delay required to find a practical means of enabling the communication to take place will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm; and
- there is no reason to believe that the person does not want the treatment.

A member shall not provide care in emergencies if he/she has reasonable grounds to believe that the person, while capable and at least 16 years of age, has expressed a wish applicable to the circumstances to refuse consent to the care.

If consent is refused by a substitute decision-maker in an emergency, a member may provide the care despite the refusal if, in the opinion of the member, the substitute decision-maker has not complied with the requirements for substitute decision-making outlined in section 67 of the HCCA .

After providing care in an emergency without consent, a member shall promptly record in the person health record the circumstances and opinions the member held regarding the care delivered during the emergency.

4 A member may only provide care for as long as is reasonably necessary to find a practical means of enabling communication to take place or to find the incapable person's substitute decision-maker. A member shall ensure that reasonable efforts are made to find a practical means of enabling communication to take place or to find the incapable person's substitute decision-maker.

If during the course of care, the person becomes capable in the opinion of the member, the person's own decision governs.

Capacity to Consent

The HCCA section 4, provides the following definition and procedure with respect to capacity:

(1) 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) A person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services.

(3) 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.

Examples of incapable patients include those who have lost mental capacity due to an illness and those minors who do not have an understanding of the examination/care or plan of care or consequences of a decision or lack of decision. Upon determining that a patient is incapable to consent, in accordance with section 15-19 of the *HCCA*, a member shall follow the following procedures:

- Inform the patient that the member is of the opinion that the patient is incapable with respect to consent to examination, care or plan of care;
- Identify the patient's substitute decision-maker in accordance with sections 20-24 of the *HCCA*;
- Obtain consent from the patient's substitute decision-maker in accordance with sections 20-24 of the *HCCA*;
- If the patient objects to the finding of incapacity or the substitute decision-maker, inform the patient of his/her right to appeal this decision to the Consent and Capacity Board.[4] This information should be communicated to the patient in a manner the patient is best able to understand; and
- Relevant information related to a determination of incapacity and a patient's substitute decision-maker must be documented in the patient health record.

The HCCA contains provisions regarding determination of incapacity, obtaining consent from a substitute-decision maker and applications to the Consent and Capacity Board. The complete HCCA is available at http://canlii.org/en/on/laws/stat/so-1996-c-2-sch-a/latest/so-1996-c-2-sch-a.html.

Examination or Treatment of Minors

The *HCCA* does not identify an age at which minors may exercise independent consent for health care because it is accepted that the capacity to exercise independent judgment for health care decisions varies according to the individual and the complexity of the decision at hand. A member is encouraged to seek consent from the appropriate substitute decision-maker (usually the parent or guardian or person with authority to make health care decisions on behalf of the child) before providing care to a minor who does not clearly have the capacity to consent to an examination, care or plan of care.

LEGISLATIVE CONTEXT

Section 3 (1) of the Health Professions Procedural Code - One of CCO's objects under the *Regulated Health Professions Act, 1991* (*RHPA*) is to "develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession."

The Quality Assurance program is defined in Ss 1(1) of the Code as "a program to assure the quality of the practice of the profession and to promote continuing competency among members."

The Professional Misconduct Regulation under the *Chiropractic Act, 1991*, includes the following as an act of professional misconduct:

2. Contravening a standard of practice of the profession or failing to maintain the standard of practice expected of members of the profession.

3. Doing anything to a patient for therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

29. Contravening a federal, provincial or territorial law, a municipal by-law or a by-law or rule of a hospital within the meaning of the *Public Hospitals Act*, if the contravention is relevant to the member's suitability to practise.

33. Engaging in conduct or performing an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Health Care Consent Act, 1996

This standard of practice includes sections of the *HCCA*. The complete *HCCA* is available at http://canlii.org/en/on/laws/stat/so-1996-c-2-sch-a/latest/so-1996-c-2-sch-a.html.

The *HCCA* contains a number of provisions relating to consent, including Ss.11 which defines the requisite elements of consent to treatment as follows:

(1)
1. The consent shall relate to the treatment.
2. The consent shall be informed.
3. The consent shall be given voluntarily.
4. The consent shall not be obtained through misrepresentation or fraud.

(2) A consent to treatment is informed if, before giving it,

(a) the person received the information about the matters set out in sub section (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and

(b) the person received responses to his or her requests for additional information about those matters.

(3) The matters referred to in subsection (2) are:

1. The nature of the treatment.
2. The expected benefits of the treatment.
3. The material risks of the treatment.
4. The material side effects of the treatment.
5. Alternative courses of action.
6. The likely consequences of not having the treatment.

In addition, there is a body of case law which supports the principle that a member shall ensure that the patient consent is fully informed and voluntarily given before the patient is examined or treated.

Sections 15 - 19 of the *HCCA* discuss the rules related to determining capacityof patients. Please see the complete *HCCA* for further details.

Section 20 - 24 of the *HCCA* discuss the rules related to obtaining consent from a substitute decision-maker. Included in this section is the list of persons who may give or refuse consent on behalf of an incapable person. Please see the complete *HCCA* for further details.

List of persons who may give or refuse consent

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(1) If a person is incapable with respect to a treatment, consent may be given or refused on his or her behalf by a person described in one of the following paragraphs:

1. The incapable person's guardian of the person, if the guardian has authority to give or refuse consent to the treatment.
2. The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment.
3. The incapable person's representative appointed by the Board under section 33, if the representative has authority to give or refuse consent to the treatment.
4. The incapable person's spouse or partner.
5. A child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This paragraph does not include a parent who has only a right of access. If a children's aid society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, this paragraph does not include the parent.
6. A parent of the incapable person who has only a right of access.
7. A brother or sister of the incapable person.
8. Any other relative of the incapable person.

Requirements

(2) A person described in subsection (1) may give or refuse consent only if he or she,

(a) is capable with respect to the treatment;
(b) is at least 16 years old, unless he or she is the incapable person's parent;
(c) is not prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf;
(d) is available; and
(e) is willing to assume the responsibility of giving or refusing consent.

Ranking

(3) A person described in a paragraph of subsection (1) may give or refuse consent only if no person described in an earlier paragraph meets the requirements of subsection (2).

Explanatory Notes

This standard of practice should be read in conjunction with the following, all of which require that consent be fully informed, voluntarily given and evidenced in a written form signed by the patient or otherwise documented in the patient health record:

- S-001: Chiropractic Scope of Practice
- S-002: Record Keeping
- S-005: Chiropractic Adjustment or Manipulation
- S-006: Technical and Interpretative Components for X-ray
- S-007: Putting a Finger Beyond the Anal Verge for the Purpose of Manipulating the Tailbone
- S-011: Members of More Than One Health Profession
- S-013: Orthotics
- G-001: Prevention of Sexual Abuse of Patients
- G-009: Code of Ethics

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[1] See the section "Capacity to Consent" for information relating to determining the capacity of a patient to consent and obtaining consent from a substitute decision maker, if necessary.

[2] See sections 25 - 28 of the *HCCA*.

[3] See *The Good Samaritan Act, 2001* for an explanation of immunity from liability for health professionals and individuals providing emergency health care in certain circumstances.

[4] The Consent and Capacity Board is an independent body created by the provincial government of Ontario under the *Health Care Consent Act, 1996*. It conducts hearings under the *Mental Health Act*, the *Health Care Consent Act*, the *Personal Health Information Protection Act*, the *Substitute Decisions Act* and the *Mandatory Blood Testing Act*. Board members are psychiatrists, lawyers and members of the general public appointed by the Lieutenant Governor in Council. The Board sits with one, three, or five members. Hearings are usually recorded in case a transcript is required.