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February 20, 2015

VIA EMAIL: [consent@cpsso.on.ca](mailto:consent@cpsso.on.ca)

Attention: Policy Department  
College of Physicians and Surgeons of Ontario  
80 College Street  
Toronto, Ontario  
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Dear Sir/Madam,

**Re: Comments on Draft Consent to Treatment Policy (Approved by Council for Consultation – deadline February 20, 2015)**

The following are the Advocacy Centre for the Elderly's comments on the Draft CPSO Consent to Treatment policy for your consideration.

**About the Advocacy Centre for the Elderly (ACE)**

To put our comments in context, we provide relevant information about the Advocacy Centre for the Elderly (ACE).

ACE is a specialty community legal clinic that was established to provide a range of legal services to low income seniors in Ontario. The legal services include individual and group client advice and representation, public legal education, community development and law reform activities. ACE has been operating since 1984 and it is the first and oldest legal clinic in Canada with a specific mandate and expertise in legal issues of the older population.

ACE staff have extensive experience in issues related to health care consent and advance care planning and have been involved in many of the law, policy, and education initiatives related to these issues that have taken place in Ontario over the last 30 years. These have included:

- participating as a member of the Fram Committee, the work of which resulted in the passage of the *Consent to Treatment Act, 1992* and subsequently the *Health Care Consent Act, 1996*,<sup>1</sup>

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<sup>1</sup> *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A (*HCCA*)

- acting as one of the principal writers of the training materials for health professionals that were produced as part of two of the Alzheimer Society of Ontario Initiatives (# 2 and #7) on Physicians' Education and Advance Directives on Care Choices;
- participating on the Ontario Medical Association Presidents Advisory Committee on Palliative Care and Advance Care Planning;
- participating currently on the Advisory Committee for the Law Commission of Ontario Project on Legal Capacity, Decision-making and Guardianship;
- engaging presently and for the past two years in a number of education initiatives for health care practitioners on health care consent and advance care planning. These include but are not limited to initiatives in the Erie-St Clair LHIN, Central East LHIN, Hamilton Niagara Haldimand Brant (HNHB) LHIN, and Northwest LHIN. These initiatives have involved interactive, detailed training sessions as well as production of an on-line training course on health care consent and advance care planning that is also a requirement of the Long-Term Care Home Service Accountability Agreements in the HNHB LHIN; and,
- co-authoring (with the law firm of Dykeman Dewhirst O'Brien LLP) a major research paper on health care consent and advance care planning for the Law Commission of Ontario.<sup>2</sup>

### **Commentary on the Consent to Treatment Draft Policy**

Overall, this version of the Draft Consent to Treatment policy accurately reflects the law on consent as set out in the *Health Care Consent Act* (the "HCCA") and is an improvement on the previous policy. We thank you for taking into consideration ACE's submissions dated November 22, 2013 in revising the policy.

We would like to recommend a few changes to the Draft policy based on our extensive experience conducting educational seminars for physicians on health care consent and advance care planning and in drafting the report referenced above on health care consent and advance care planning for the Law Commission of Ontario. These experiences have helped us identify common misunderstandings of physicians in the area of health care consent, which can be rectified by further clarification in the Draft policy.

#### **1. Introduction – "informed" consent (Line 10)**

We appreciate that the first part of this policy sets out the basic requirement for consent and the description of consent as "informed" appears later in the policy . However, one of the most common problems we have identified both in our legal practice and in

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<sup>2</sup> Judith Wahl, Mary Jane Dykeman and Brendan Gray, *Health Care Consent and Advance Care Planning in Ontario: Legal Capacity, Decision-Making in Guardianship*, Law Commission of Ontario: January 2014, available at: <http://www.lco-cdo.org/capacity-guardianship-commissioned-paper-ace-ddo.pdf>

conducting education sessions for physicians is that the legal requirement that consent is to be “informed” is not well understood and not always operationalized.

In our education sessions, many physicians have told us that they assumed consent was simply obtaining a yes or no answer to the proposed treatment and that they did not appreciate that consent involved providing the patient or substitute decision-maker (SDM) information on the risks, benefits, side effects, alternatives to the treatment and the health consequences if treatment was refused and providing them with answers to any questions or requests for further information that they may have with respect to treatment. Further, in a number of our long-term care cases, a physician has charted that a particular drug should be provided to an incapable resident of the care home, leaving it up to the nursing staff to “inform” the SDM of the treatment. The nursing staff may merely advise the SDM of the new drug after treatment has commenced, provide the SDM with vague explanations of the new drug or not advise the SDM at all unless the SDM asks the nursing staff whether any new drugs are being administered. The incapable resident may not be able to inform the SDM of the change in treatment and, as such, the SDM can be entirely reliant on the staff to be advised of treatment. In these cases, neither the physician nor the nurse is providing the SDM with the information required for informed consent to treatment and are therefore treating the patient illegally.

Placing emphasis on informed consent at the outset of the Draft policy, in the introduction, and providing a footnote to refer the reader to the later sections in the Draft policy would help to ensure that physicians understand that consent involves communication of information to and answering the questions of the patient or the SDM.

**We recommend that the word “informed” preface the word “consent” in line 10 and a footnote should be inserted to refer to the section in the Draft policy titled “What Elements are Required for Consent”.**

## **2. Use of Family Members instead of Third Party Interpreters (Lines 45 to 54)**

The Draft policy provides that a physician may use family members instead of third party interpreters to ensure that a patient has understood the information necessary to provide consent to treatment.

In the recent case of *P.S. v. Ontario*,<sup>3</sup> the Ontario Court of Appeal was highly critical of a psychiatric facility not providing American Sign Language interpretation to the appellant who had been involuntarily committed under the *Mental Health Act*.<sup>4</sup> Applying the Supreme Court’s decision in *Eldridge v. British Columbia (Attorney General)*,<sup>5</sup> the Court found that as the appellant had not been provided with adequate interpretation services, as such his right to equality guaranteed under the *Canadian Charter of Rights and Freedoms* was violated. The Court specifically mentioned the necessity to utilize interpretation services in obtaining the appellant’s consent to or refusal of treatment, stating that:

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<sup>3</sup> *P.S. v. Ontario*, 2014 ONCA 900 (CanLII), <<http://canlii.ca/t/gfr85>>

<sup>4</sup> *Mental Health Act*, R.S.O. 1990, c. M.7

<sup>5</sup> *Eldridge v. British Columbia (Attorney General)*, 1997 CanLII 327 (SCC), [1997] 3 S.C.R. 624

To obtain a patient's informed consent to treatment, the hospital needs to be able to communicate information respecting the nature of the illness as well as the risks and benefits of either *refusing or accepting* the proposed treatment. In my view, the provision of information regarding proposed therapeutic interventions, as well as the corresponding communication of consent or refusal, requires 'effective communication' through deaf appropriate services."<sup>6</sup>

While this decision was made in respect of a deaf appellant, the right to equality would likely be infringed where a physician's mode of communication was a barrier to obtaining informed consent from a patient with a disability. In light of *P.S. v. Ontario* and earlier decisions of the courts, physicians must be extremely cautious when deciding not to use the services of an interpreter to ensure that a patient's consent to or refusal regarding the proposed treatment is valid, given a patient's abilities. After all, it is the legal duty of the physician to obtain valid consent prior to treatment.

More broadly, considering the requirement of informed consent under the *HCCA*, a qualified interpreter should be used whenever there is a barrier to understanding the language used by the physician to provide information respecting treatment to the patient. Further, as noted in the Draft policy, conflicts with families may be a reason not to use family members as interpreters. Our experience indicates that family members can be perpetrators of abuse against older adults. The family may also wish to protect the older adult by shielding them from health care information that the family believes the older adult may find upsetting. As such, we are concerned that the use of these family members as interpreters may perpetuate abuse or prevent the flow of information by hindering communication between the physician and the patient to the detriment of the patient.

Telephone interpretation is accessible in many parts of the province, at least, to assist with patients that are able to use a regular telephone. For example, the University Health Network provides interpretation services by telephone for follow-up visits and diagnostic tests.<sup>7</sup> The Toronto Central LHIN has also set up a centralized language services hub, offering professional interpreters to its members.<sup>8</sup>

**We recommend that lines 45 to 54 be revised to indicate that a physician should be cautious in using family members rather than a qualified interpreter when providing information to a patient and obtaining consent to treatment, especially where there is a concern that a patient may not be able to understand the physician's chosen mode of communication or there is potential for abuse by family members.**

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<sup>6</sup> *P.S. v. Ontario, supra*, note 3 at paragraph 151

<sup>7</sup> Language Services, *University Health Network*, available at:

<sup>8</sup> Carol Goar, "Toronto's diverse population requires multilingual health care", *Toronto Star* (August 7, 2014) accessible at:  
[http://www.thestar.com/opinion/commentary/2014/08/07/torontos\\_diverse\\_population\\_requires\\_multilingual\\_health\\_care\\_goar.html](http://www.thestar.com/opinion/commentary/2014/08/07/torontos_diverse_population_requires_multilingual_health_care_goar.html)

### 3. Elements Required for Valid and Informed Consent (Line 70)

The draft policy includes a summary chart of the framework and key requirements for consent to treatment. In the sections titled “Policy” and “What Elements are Required for Consent”, “informed” consent is listed as an element of “valid” consent. However, as stated in our first comment above, the requirements of “informed” consent are not always understood.

We also have found that the withdrawal of consent is misunderstood. A common complaint from SDMs is that when they withdraw consent to treatment, they are informed by nursing staff that treatment cannot stop until the physician discontinues the treatment. The patient should not continue to be treated if consent for that treatment has been withdrawn.<sup>9</sup>

As the chart is intended to be a summary that some physicians may use as a quick reference, this chart could be strengthened by adding an additional section on the elements of informed consent and withdrawal of consent.

**We recommend that further boxes be added to the chart at Line 70, providing the elements of informed consent and information regarding the withdrawal of consent.**

<b>What is informed consent</b>	<b>For consent to be informed, prior to obtaining consent, physicians must provide information about the nature of the treatment, its expected benefits, its material risks and side effects, alternative courses of action and the likely consequences of not having the treatment. Physicians must provide information that a reasonable person in the same circumstances would require in order to make a decision about the treatment. The physician must also respond to requests for additional information either from the patient or, if the patient is incapable, from the SDM.</b>
<b>What is withdrawal of consent</b>	<b>Consent that is given by or on behalf of the person may be withdrawn at anytime. A patient can no longer be treated if consent to treatment is withdrawn by the capable patient or, if the patient is incapable, the SDM.</b>

### 4. Who to Obtain Consent From (Line 87 to 102)

Through our education programmes, it has become evident that health practitioners, including physicians, do not have a good understanding of who is/are SDM(s) for an incapable patient. Further, our research has indicated that hospital, health facility, and health records forms rarely include the hierarchy list of SDMs or even use the term “SDM.” Instead, these forms refer to “next of kin” or “POA”, presumably referring to attorneys for personal care. Even the MDS-RAI forms include a list of potential SDMs

<sup>9</sup> HCCA, *supra* note 1, section 14

which is not reflective of Ontario law. These forms may be contributing to the confusion regarding the hierarchy of SDMs as set out in the *HCCA*.

The Draft policy contains an explanation of the SDM hierarchy in the section titled “Substitute Decision-Makers and Incapable Patients.” Nevertheless, referring to the SDM hierarchy earlier in the section titled “Who to Obtain Consent From” would avoid confusion and trigger the physician to the fact that there is a hierarchy amongst potential SDMs.

Further, the section is silent until line 111 on who determines capacity. It would be useful for the physician to know almost immediately that the responsibility to determine capacity with respect to treatment rests with the health practitioner who proposes the treatment or, if a plan of treatment is proposed, with one of the health practitioners on behalf of all the health practitioners involved. The section should also include an indication that capacity is not based on a diagnosis, such as dementia, but must be considered by the physician in respect of the treatment proposed.

**We recommend that line 87 refer to the “appropriate” SDM or “appropriate SDM in the SDM hierarchy.”**

**We also recommend that the section titled “Capacity” begin by stating that the health practitioner proposing the treatment or a health practitioner on behalf of all health practitioners proposing a plan of treatment determines the capacity of the patient and include a statement that capacity is not based upon diagnosis.**

#### **5. Authorization to Make Decisions as a Guardian or Attorney for Personal Care (Lines 118 to 119)**

The list providing the hierarchy of individuals or agencies who may give or refuse consent in the Draft policy includes guardians for personal care, if authorized, or attorneys for personal care, if authorized.

The ability to make personal care decisions includes making decisions about health care, but also incorporates a wide range of other decisions in areas such as nutrition, shelter, clothing, hygiene or safety. Therefore, when a court appoints a guardian for personal care or a person is made an attorney for personal care, the court order or the power of attorney for personal care may not specify that the guardian or attorney is able to make health care decisions, but may more broadly indicate that the guardian or attorney can make personal care decisions.

On the other hand, a court may appoint a person as a partial guardian for an incapable person, if the court finds that the person is incapable in respect of some but not all aspects of personal care. The court must specify the functions of which the person is found to be incapable in the court order.<sup>10</sup> Similarly, a person could be made attorney for

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<sup>10</sup> *Substitute Decisions Act, 1992*, S.O. 1992, c. 30, section 60

personal care but certain treatments or functions could be exempted from the power of attorney.

The physician should carefully review the court order or power of attorney to ensure that the SDM is in fact authorized to make treatment decisions for the patient. Nevertheless, the term “if authorized” should be clarified in the Draft policy as it can be confusing and may lead a physician to believe that the court or the power of attorney must specifically authorize the guardian or attorney to make health care decisions, rather than merely reference personal care.

**We recommend that the Draft policy should advise physicians to review documents purporting to authorize an SDM to make treatment decisions.**

**We also recommend that the term “if authorized” at lines 118 to 119 in the context of guardians or attorneys in the SDM hierarchy be explained to indicate to the physician that the guardian or attorney can be generally be appointed with respect to personal care, which includes health care.**

## **6. Multiple Persons at the Same Rank (Line 138)**

The Draft policy indicates that the SDM for the incapable patient may be more than one person within the same rank of the SDM hierarchy.

Nevertheless, the Draft policy does not indicate that multiple persons at the same rank within the SDM hierarchy make decisions unanimously nor that all of the persons of the same rank make decisions unless they choose amongst themselves as to who will act as SDM. It should also be noted that there is no requirement that multiple persons at the same rank within the SDM hierarchy appoint someone to act for all of them. Further, if there is a disagreement on whether to give or refuse consent to a particular treatment, the decision must be made by the Public Guardian and Trustee.<sup>11</sup> While there is reference to the Public Guardian and Trustee at line 164 of the Draft policy, however, it would be helpful to include information earlier in the policy respecting what occurs if there is a disagreement between SDMs of the same rank.

**We recommend that line 138 indicate that multiple persons at the same rank within the SDM hierarchy make decisions unanimously or that they all make decisions unless and if they can choose amongst themselves who will act, and that the decision will be made by the Public Guardian and Trustee in the event of any disagreement between the SDMs of the same rank on whether to provide or refuse consent to treatment.**

## **7. Responsibility of Physician to Advise SDMs of their Obligations (Lines 147 to 159)**

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<sup>11</sup> HCCA, *supra* note 1, section 20(5)

SDMs may not be aware that there are particular requirements for decision-making that they must follow when making decisions on behalf of the incapable patient. The Ontario Court of Appeal held in *Benes v. A.M.*<sup>12</sup> that physicians have a legal obligation to advise SDMs of their decision-making obligations and ensure that SDMs understand the requirements for decision-making under the *HCCA* when deciding whether to provide or refuse consent to a proposed treatment.

**We recommend that the Draft policy include a statement advising physicians of their obligation to explain to SDMs the requirements for decision-making outlined at lines 147 to 159 of the Draft policy.**

**We also recommend that another box be added in the chart at Line 70, indicating the responsibility of a physician to advise an SDM of his or her obligations.**

<b>What are a physician's obligations when obtaining consent</b>	<b>Physicians have a legal obligation to advise SDMs of their decision-making obligations and ensure that SDMs understand the requirements for decision-making under the <i>HCCA</i> when deciding whether to provide or refuse consent to a proposed treatment.</b>
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#### **8. Authority of Wishes/Directions in an Advance Care Plan (Line 152)**

The Draft policy provides that wishes can be expressed in writing or orally. The footnote to line 152 indicates that written wishes can include advance care planning documents and includes a reference to the CPSO's separate policy on Decision-making for the End of Life.

The Draft policy should be revised to indicate that wishes can be expressed by means other than in writing or orally, as stated in the *HCCA*.<sup>13</sup>

The CPSO Decision-making for End of Life policy refers to advance care planning and advance directives. Our comments about that Policy will be made in a separate letter. Although the other policy exists, owing to the confusion on this particular subject that we have observed in our education sessions and through our research, we suggest that some reference be made in this Draft policy to advance care planning.

In particular, we suggest that the Draft policy indicate that advance care plans are not advance "consent" and that consent can only be obtained from a person. It is only the SDM that interprets the wishes or directions of an incapable patient expressed in any advance care plan, whether oral, written, or expressed by other means. The Draft policy should also note that SDMs cannot advance care plan on behalf of incapable patients.

<sup>12</sup> *Benes v. A.M.*, 1999 CanLII 3807 (ON CA) at paragraph 23

<sup>13</sup> *HCCA*, *supra* note 1, section 5(2)

Owing to the significant volume of information being distributed on advance care planning in health facilities and in the health system, some of which may not be legally correct, it is vital to clarify this particular point in this Draft policy, as well as provide further explanation in the Decision-making for End of Life policy.

**We recommend that line 152 in the Draft policy be revised to indicate that wishes may, in addition to being expressed in writing or orally, be expressed in any other manner, and that a statement be included in the Draft policy that wishes in an advance care plan or advance directive are to be interpreted by the patient's SDM and do not constitute consent or refusal of consent. It should also include a statement that SDMs cannot advance care plan on behalf of incapable patients.**

#### **9. Rights Information and Patient Right of Review of Finding of Incapacity (Lines 171 to 172)**

The Draft policy correctly provides that any patient who disagrees with a finding of incapacity can apply to the CCB for a review of the finding of incapacity.

However, the Draft policy does not indicate that a physician should inform the patient of the significance of the finding and of the right to apply to the CCB for a review of the finding. As a consequence of independent rights advice being limited to psychiatric facilities, the information to be provided to the patient found incapable of consenting to treatment should be provided by the physician making the finding of incapacity.

The previous CPSO policy on consent to treatment (Policy 4-05) at page 6 advised the physician to inform the patient of his or her options on a finding of incapacity including the right to apply to the CCB for review of the finding of incapacity. Further, the policy indicated that the physician should reasonably assist the patient if he or she expresses a wish to exercise this option. This could include providing the patient with a contact for the lawyer referral service of the Law Society of Upper Canada or a contact for a legal clinic to assist the incapable person to obtain counsel. The patient should also be advised that the finding of incapacity can be challenged again in six months.<sup>14</sup>

**We recommend that lines 171 to 172 include advice to physicians that they should inform patients of their right to seek a review of the finding of incapacity, reasonably assist patients to access that right, and inform patients that they would be able to review the finding of incapacity again in six months.**

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<sup>14</sup> *Ibid.*, section 32(5)

**Conclusion**

We would like to thank the CPSO for this opportunity to provide feedback on the Draft Consent to Treatment policy, and would be pleased to clarify or discuss any aspect of this commentary going forward.

Yours truly,  
**ADVOCACY CENTRE for the ELDERLY**

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