

Consent to Treatment in Long-Term Care Homes: The Case of *Re SW*

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The use of antipsychotics in long-term care homes has recently been a matter of much concern in the media. Studies in Ontario have shown a high rate of use of these medications in long-term care residents, even though these medications are not approved for treatment of dementia-related behaviours. Further, increased mortality rates, as well as increased risks for sedation, falls, cardiovascular events and renal injury make the use of these medications controversial in older adults.¹

One contributing factor to overuse of antipsychotics in long-term care is that health practitioners regularly fail to obtain valid informed consent for their use. This leads to their overuse as residents or, where the resident is incapable, their substitute decision-makers are not afforded the opportunity to decide for themselves whether or not these medications are appropriate.

In Canada, medical treatment cannot take place without the health practitioner first obtaining “informed consent.” This means that a treatment cannot begin until the patient or their substitute decision-maker is provided with information about the treatment and they decide to go ahead with the treatment.²

In Ontario, these rules are codified in the *Health Care Consent Act, 1996 (HCCA)*, which provides the roadmap for how consent is to be obtained. Except in an emergency, prior to the start of any medical treatment a health practitioner must obtain an informed consent to the treatment.³ In order for consent to be valid it must:

1. relate to the treatment;
2. be informed;
3. be given voluntarily; and
4. not be obtained through misrepresentation or fraud.⁴

In order for consent to be “informed”, the patient must be told:

1. the nature of the treatment;
2. the expected benefits of the treatment;

¹ See for example *Antipsychotic Use in the Elderly, Final Consolidated Report*, Ontario Drug Policy Research Network, June 2015, available at http://brainxchange.ca/getattachment/Public/Topics-A-to-Z/Drugs/ODPRN_Antipsychotics_Consolidated-Final-Report_June-3-2015-1.pdf.aspx

² *Reibl v. Hughes*, [1980] 2 SCR 880, 1980 CanLII 23(SCC).

³ *HCCA*, S.O. 1996, c. 2, Sched. A, s. 10.

⁴ *Ibid.* s. 11(1).

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; and,
7. they must be given responses to requests for any additional information about these matters.⁵

Consent must be obtained from a competent person, which means that the person must have both the ability to understand the information relevant to making the decision and the ability to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.⁶

If the health practitioner proposing the treatment believes that the person is not capable of making such a decision, they must advise the allegedly incapable person of their finding and of their right to apply to the Consent and Capacity Board (CCB) to challenge that finding.⁷

If the person does not challenge the finding, or after any challenges are resolved and the person remains incapable, the health practitioner must then turn to the incapable person's substitute decision-maker for consent. The requirements for, and list of, the hierarchy of substitute decision-makers is set out in section 20 of the *HCCA*.

These requirements are in place to ensure the autonomy of the patient. This is important, as different people have different views on treatments (for example, some treatments may be contrary to religious beliefs); the person may have sensitivities or allergies which would otherwise be unknown to the health practitioner; and different people have different risk tolerances. This last is very important, as individuals weigh risks and benefits of treatments very differently. Some people are willing to take greater risks than others. This is a very personal decision, and not one that a health practitioner is entitled to determine.

When it comes to treatment with antipsychotics, especially in the elderly, the issue of risks and benefits is extremely important, given the risks related to the use of these medications outlined above, and the lack of evidence as to their efficacy in the elderly with dementia.

In ACE's experience, even though consent to treatment is legally required, health practitioners in long-term care homes often do not comply with the law. This is in part due to a lack of understanding of the law by the health professionals, and in part due to a lack of enforcement by the various oversight bodies in enforcing the rules.

⁵ *Ibid.*, s. 11(2) & (3).

⁶ *Ibid.*, s. 4.

⁷ *Ibid.*, s. 17, and see individual policies of each regulated health professions.

The recent case of *Re SW*⁸ is a prime example of the failure to obtain valid consent to treatment in a long-term care home.

SW was a resident of a long-term care home. She was being treated with medication and no consent had been sought from her. SW commenced an application before the Consent and Capacity Board to review a finding of incapacity. At the hearing, SW's counsel, Mark Handelman brought a preliminary motion that SW's capacity had never been determined and, therefore, the physician could not rely on the consent of a substitute decision-maker.

The evidence showed that SW's medical chart contained no indication that there had ever been a finding of incapacity. The evidence of the physician who prescribed the medication was that while she had concerns about SW's capacity, she had never formally assessed it. Neither had she ever had any discussion with SW about her capacity. She had not discussed the finding of incapacity, or informed SW that she had a right to challenge any finding of incapacity.

At the hearing, the prescribing physician gave the following evidence in cross-examination from Mr. Handelman:

Q. Okay, so she is answering your questions responsively, did you tell her about any of the medications you were prescribing to her?

A. No.

Q. So I guess that means you didn't tell her about the risks and benefits of them either?

A. No.

Q. So you can't speak specifically to whether she was able to understand information about the risks or benefits of those medications?

A. No.

Q. And you can't speak specifically whether or not she was able to appreciate the consequences of giving or refusing consent herself to any of those medications. Is that fair?

A. That's correct.

Q. And you just assumed that it would be the attorney for personal care that would be giving consent to treatment without actually assessing my

⁸ In the Matter of SW, Consent and Capacity Board, Order/Endorsement of Paul DeVillers, Presiding Member, April 29, 2016, 15-5454-01; 15-545-02, unreported

client's capacity yourself, or finding a prior specific capacity assessment addressing her specific capacity to make treatment decisions? Is that fair?

A. That's correct because that is the way it happens in nursing homes.⁹

Based on this evidence, the Board held that there had been no relevant determination of capacity and disposed of the hearing. Under Ontario law, in the absence of a finding of incapacity a person is presumed to be mentally capable of making treatment decisions.¹⁰

This case is an example of a common misconception in long-term care homes: that residents are incapable, and that the health practitioner can simply go to a substitute decision-maker to obtain consent for treatments without determining capacity or obtaining informed consent from a resident.

Residents often tell us that they must take medications because "the doctor ordered it". Nursing staff will administer medication to residents over their objection, or the objection of the substitute decision-maker, because it is contained in a doctor's order. Long-term care home staff often believe that because a person is admitted to a long-term care home, or because they were found incapable of making an admission decision by the Community Care Access Centre, that the person is incapable of making treatment decisions. All of these issues demonstrate a lack of understanding of the consent process.

The failure of health practitioners to comply with the *HCCA* is an ongoing problem in long-term care homes. Without the correct information, residents or substitute decision-makers are not able to determine whether a proposed treatment is appropriate to their circumstances. Given the vulnerability of residents in long-term care, they often believe they cannot speak up when given medication they have not consented to. Failing to obtain valid consent is not only contrary to the *HCCA*, it is also misconduct under the various health profession conduct codes,¹¹ contrary to the *Long-Term Care Homes Act*¹², and opens the health professional up to legal action for negligence and/or battery.

Health professionals and long-term care homes have a legal obligation to educate themselves in the law related to consent to treatment and should be vigilant in ensuring compliance. Residents, their families, and substitute decision-makers should also educate themselves to ensure that the consent process is followed and treatment only provided after informed consent is given by a legally authorized person.

⁹ Evidence of evidence, *In the Matter of S.W.* (Consent and Capacity Board, April 29, 2016)

¹⁰ *HCCA*, *supra* note 3, s. 4(2)

¹¹ For example, see O. Reg. 856/93: Professional Misconduct under the *Medicine Act*, s. 1 9.

¹² s. 3(1)11.