College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

Guide to the Health Care Consent Act

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Introduction

Midwives have a professional and legal obligation to obtain informed consent prior to providing treatment to clients.

The College's professional standards require that midwives recognize clients as the primary-decision makers and provide informed choice in all aspects of care by:

- Providing information so clients are informed when making decisions about their care
- Advising clients about the nature of any proposed treatment, including the expected benefits, material risks and side effects, alternative courses of action and likely consequences of not having treatment
- Making efforts to understand and appreciate what is motivating clients' choices
- Allowing clients adequate time for decision-making
- Ensuring treatment is only provided with the client's informed and voluntary consent unless otherwise permitted by law
- Supporting clients' right to accept or refuse treatment
- Respecting the degree to which clients want to be involved in decisions about their care[1]

In addition to midwives' professional obligations, midwives are legally required to obtain consent prior to providing treatment.

Failure to obtain consent in situations where consent is required by law is professional misconduct under the College's *Professional Misconduct Regulation*[2] under the *Midwifery Act*.[3] It may also result in midwives being held liable in court through civil proceedings.

A midwife's legal obligations for obtaining consent is set out in the *Health Care Consent Act* ("*HCCA*").[4] The purpose of this guide is to outline these obligations. However, it is not intended to exhaustively cover all of the obligations. In the event a midwife is unsure of their legal obligations in specific circumstances, the College recommends that they seek independent legal advice.

Capacity for Consenting to Treatment

Midwives must assess whether clients have the capacity to consent to treatment and if not, which substitute decision maker should be involved.

What Consistutes Treatment

Under the *HCCA*, a treatment is anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health related purpose

[1] 16.1-16.7, Professional Standards (June 2018).
[2] O. Reg. 388/09
[3] S.O. 1991, c. 31.
[4] S.O. 1996, c. 2, Sched. A

including a course of treatment or plan of treatment.[5]

The following activities do not constitute treatments under the *HCCA*:

- The assessment of capacity or the general assessment of the client's condition
- Taking a client's heath history
- Communicating assessment findings
- Admitting the client to a hospital or other facility
- Treatment that poses little or no risk of harm to the client[6]

Assessing Capacity for Treatment

Pursuant to the *HCCA*, midwives cannot administer a treatment proposed for a client or must take reasonable steps to ensure that it is not administered, unless:

(1) they are of the opinion that the client is capable with respect to treatment and has given consent; or [7]

(2) they are of the opinion that the client is incapable with respect to the treatment, and the client's substitute decision maker has given consent on the client's behalf[8]

A client is considered to have the capacity to consent to treatment when they understand the information relevant to making a decision about the treatment and appreciate the reasonably foreseeable consequences of a decision or lack of a decision.[9]

Under the Act, minors are able to make their own decisions about their health. Therefore, midwives are expected to ascertain the capacity of minors to consent to treatment.

As newborns do not have the capacity to provide consent, midwives must seek the consent of their parents prior to administering treatment to them. The only exception to this is where permitted by law.

Involving Substitute-Decision Makers

A substitute decision maker is defined in the *HCCA* as a person who is authorized under s. 20 of the *HCCA* to give or refuse consent to treatment on behalf of a client who is incapable with respect to the treatment.[10]

The requirements that entitle a substitute decision maker to give or refuse consent are:

- they are capable with respect to the treatment;
- are at least 16 years old, unless they are the incapable person's parent;
- are 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;
- are available; and
- are willing to assume the responsibility of giving or refusing consent[11]

The *HCCA* provides a hierarchy of substitute decision makers. This hierarchy operates as a ranking system, such that the person or group of people that are ranked highest on the list is given precedence. It is only if that person or group of people does not meet the requirements that entitles them to give

[5] *Ibid*, s. 2(1).
[6] *Ibid.*
[7] *Ibid*, s. 10(1)(a).
[8] *Ibid*, s. 10(1)(b).
[9] *Ibid*, s. 4(1).
[10] *Supra*, note 4, s. 9.
[11] *Ibid*, s. 20(2).

or refuse consent that the next highest ranking person or group of people will be considered. The hierarchy is as follows:[12]

1. Guardian of the client, if the guardian has the authority granted by a court to give or refuse consent
2. The client's attorney for personal care
3. Someone appointed as a representative by the Consent and Capacity Board ("Board")
4. The client's spouse, partner or relative in the following order:
   (1) Spouse or partner;
   (2) Child (if aged 16 or older unless they are the incapable client's parent) or parent of the incapable client, or 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
   (3) A parent of the incapable client who only has a right of access.
   (4) A brother or sister of the incapable client.
   (5) Any other relative of the incapable client.[13]

In the event that two or more substitute decision makers of the same rank, who rank ahead of all others, and who satisfy all the requirements for substitute decision makers, disagree about whether to give or refuse consent, the Public Guardian and Trustee will make that decision.[14]

When identifying a substitute decision maker, midwives can rely on the representation made by the individual about their relationship to the client, unless there is reason to believe that the representation is false.[15]

Challenging Capacity

In most cases, a midwife may presume that a client has the capacity to consent. However, there may be cases where a midwife questions capacity, such as when providing care to clients with cognitive disabilities or clients with impaired thinking due to substance abuse. In such cases, a midwife will have to assess whether the client has the capacity to consent to treatment.

A midwife should discuss the proposed treatment with the client and attempt to measure the client's understanding of the treatment. If the midwife is of the opinion that the client lacks the capacity to consent, the midwife should inform the client of this and of the client's right to appeal the midwife's opinion to the Board.

In the event a midwife is of the opinion that a client is incapable with respect to the treatment but is found to be capable by the Board on an application for review of the midwife's opinion, or by a court of appeal on the Board's decision, the midwife cannot administer the treatment and must take reasonable steps to ensure that it has not been administered, unless the client has given consent.[16]

If a client takes no issue with the midwife's opinion, the midwife should involve the client's substitute decision-maker in providing or refusing consent on behalf of the client. If the client disagrees with the involvement of a

[12] See Appendix "A" for flowchart.
[13] *Ibid*, s. 20(1). Midwives are expected to be familiar with this provisions and others governing the selection of substitute decision makers.
[14] *Ibid*, s. 20(6).
[15] *Ibid*, s. 29(6).
[16] *Ibid*, s. 10(2).

particular substitute, the member should speak with the client and/or family members to determine the highest ranking individual to make decisions for the client in accordance with the *HCCA*.

Elements of Consent

In order for consent to treatment to be valid, it must:

- relate to the treatment[17]
- be informed (see below)[18]
- be given voluntarily,[19] which requires midwives to ensure that a client is not being coerced into giving consent
- not be obtained through misrepresentation or fraud,[20] which requires that midwives conduct honest informed choice discussions with clients about proposed treatments

Consent is considered to be informed if before giving consent, the client:

(1) Received information about:
   a. The nature of the treatment
   b. The expected benefits of the treatment
   c. The material risks[21] of the treatment
   d. The material side effects[22] of the treatment
   e. Alternative courses of action
   f. The likely consequences of not having the treatment; and[23]

(2) Received responses to their requests for additional information about those matters[24]

In obtaining informed consent, midwives should be satisfied that the client understands the information presented to them. This requires that a midwife consider a client's age, condition, language skills and any other factors that might affect their understanding.

Under the *HCCA*, midwives are entitled to presume that consent to a treatment includes:

- consent to any variations or adjustments to the treatment if the expected benefits, material risks and side effects of the changed treatment are not significantly different than those of the original treatment[25]
- consent to the continuation of the same treatment in a different setting, if there is no significant change in the setting in which it is administered.[26] Midwives should note that moving from a home birth plan to a hospital birth plan or vice-versa would require consent to be obtained again

How Consent May be Given

Consent may be express or implied. Express consent is an unequivocal expression of consent that is direct and clear. It can be given orally or in writing.

Implied consent is inferred from the words or behaviour of a client, or

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[17] *Ibid*, s. 11(1)(1.)
[18] *Ibid*, s. 11(1)(2.)
[19] *Ibid*, s. 11(1)(3.)
[20] *Ibid*, s. 11(1)(4.)
[21] "Material" refers to information that a reasonable person, in the client's position, would find to be important when making decisions about the treatment. This definition comes from the case *Reibl v Hughes*, 1980 2 SCR 880 and is also referenced in s. 11(2) of the *HCCA*.
[22] *Ibid.*
[23] *Supra*, note 4, s. 11(2)(a) and (3).
[24] *Ibid*, s. 11 (2)(b).
[25] *Ibid*, s. 12(a).
[26] *Ibid*, s. 12(b).

surrounding circumstances, such that a reasonable person would believe consent has been given. For example, if a midwife recommends that a client get an episiotomy based on a low fetal heart rate during labour, if a client is in a lot of pain and simply nods their head and leans back to position themselves for treatment, but does not say "yes", it would be reasonable for the midwife to infer from the client's behaviour that consent has been provided.

While the *HCCA* allows for consent to be express or implied, the College strongly advises midwives to obtain express consent when possible, especially in those circumstances where the treatment provided is likely to be painful and carries significant risks.

However, midwives are reminded that simply obtaining a signature on a document or having a client or substitute decision maker say "yes" without obtaining consent as required by the *HCCA*, would not constitute valid consent.

Midwives are also reminded to always contemporaneously document informed choice discussions and consent to treatments in the client's record or through a late entry note in those circumstances where contemporaneous notes cannot be made. The notes should include:

- the date of the conversation
- who was involved or present for the conversation
- any risks that were communicated including the risks of refusing consent to treatment
- whether consent was given and by whom

In the event that a client or substitute decision maker has provided implied consent, midwives should note what about the client's or substitute decision maker's behavior and/or surrounding circumstances led the midwife to infer consent for treatment.

Withdrawal of Consent

Consent that has been given by a client or on behalf of a client may be withdrawn at any time by the client if the client is capable with respect to the treatment at the time of withdrawal,[27] or by a client's substitute decision maker, if the client is incapable with respect to the treatment at the time of the withdrawal.[28]

Emergency Treatments, Examinations & Diagnostic Procedures

The *HCCA* allows for a treatment to be administered without consent to a client who is incapable with respect to the treatment if the midwife is of the opinion that:

- there is an emergency; and[29]
- the delay required to obtain consent or refusal on the client's behalf will prolong the suffering that the client is apparently experiencing or will put the client at risk of sustaining serious bodily harm[30]

The *HCCA* also allows for treatment to be administered without the consent of a capable person if:

- there is an emergency;
- the communication required in order for the client to give or refuse consent to the treatment cannot take place because of a language barrier or the client has a disability that prevents the

[27] *Ibid*, s. 14(a).
[28] *Ibid*, s. 14(b).
[29] *Ibid*, s. 25(2)(a).
[30] *Ibid*, s. 25(2)(b).

communication from taking place;
- reasonable steps have been taken to find a practical means of communicating with the client but no such means have been found;
- the delay required to find a means to communicate will prolong the suffering of the client or put the client at risk of sustaining serious bodily harm and;
- there is no reason to believe that the client does not want the treatment.[31]

The *HCCA* also allows for an examination or diagnostic procedure to be conducted by a midwife without consent if:

- the examination or diagnostic procedure is reasonably necessary in order to determine whether there is an emergency; and
- in the opinion of the midwife,
    - the client is incapable of providing consent with respect to the examination or diagnostic procedure, or
    - the communication required in order for the client to give or refuse consent to the examination or diagnostic procedure cannot take place because of a language barrier or the client has a disability that prevents the communication from taking place;
    - reasonable steps have been taken to find a practical means of communicating with the client but no such means have been found; and
    - the delay required to find a means to communicate will prolong the suffering of the client or put the client at risk of sustaining serious bodily harm.

In either case of providing treatment or an examination or diagnostic procedure in an emergency circumstance, a midwife must record the opinions on which they relied in deciding to proceed without the client's consent, in the client's health record.[32]

The *HCCA* requires that a midwife not administer any emergency treatments if they have reasonable grounds to believe that the client, while capable and after attaining the age of 16, expressed a wish applicable to the circumstances to refuse consent to the treatment.[33]

In the case an emergency treatment is provided, any treatment can only be continued for as long as is reasonably necessary to find the incapable person's substitute decision maker and to obtain their consent or refusal of consent to the treatment.[34]

In the case of an emergency examination or diagnostic procedure, it may only be continued for as long as is reasonably necessary to find a means of communicating with the client so they can give or refuse consent to the examination or diagnostic procedure.[35]

The *HCCA* further requires that when an emergency treatment, examination or diagnostic procedure begins, a midwife must ensure that reasonable efforts are made to find the substitute decision-maker for the client or a means to

[31] *Ibid*, s. 3(a-e).
[32] *Ibid*, s. 25(5).
[33] *Ibid*, s. 26.
[34] *Ibid*, s. 25(6).
[35] *Ibid*, s. 25(7).

communicate with the client, as the case may be.[36]

However, the *HCCA* allows for a midwife to continue treatment despite a substitute decision maker giving or refusing consent to treatment if it is the midwife's opinion that there is an emergency and the substitute decision maker did not give or refuse consent in accordance with a wish expressed by the client while capable and after attaining the age of 16 or in the case of no wish, the substitute decision maker is not acting in the incapable person's best interests.[37]

The meaning of "best interests" is defined in the *HCCA*. It requires that a midwife or substitute decision maker consider:

- the values and beliefs that the person knows the incapable client held when capable and believes he or she would still act on if capable;
- any wishes expressed by the incapable client with respect to the treatment
- whether the treatment is:
    - likely to improve the incapable client's condition or well-being
    - prevent or reduce the extent or rate at which the incapable client's condition or well-being would deteriorate
- whether the incapable client's condition or well-being is likely to improve, remain the same or deteriorate without the treatment
- whether the benefit the incapable client is expected to obtain from the treatment outweighs the risk of harm to him or her
- whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed[38]

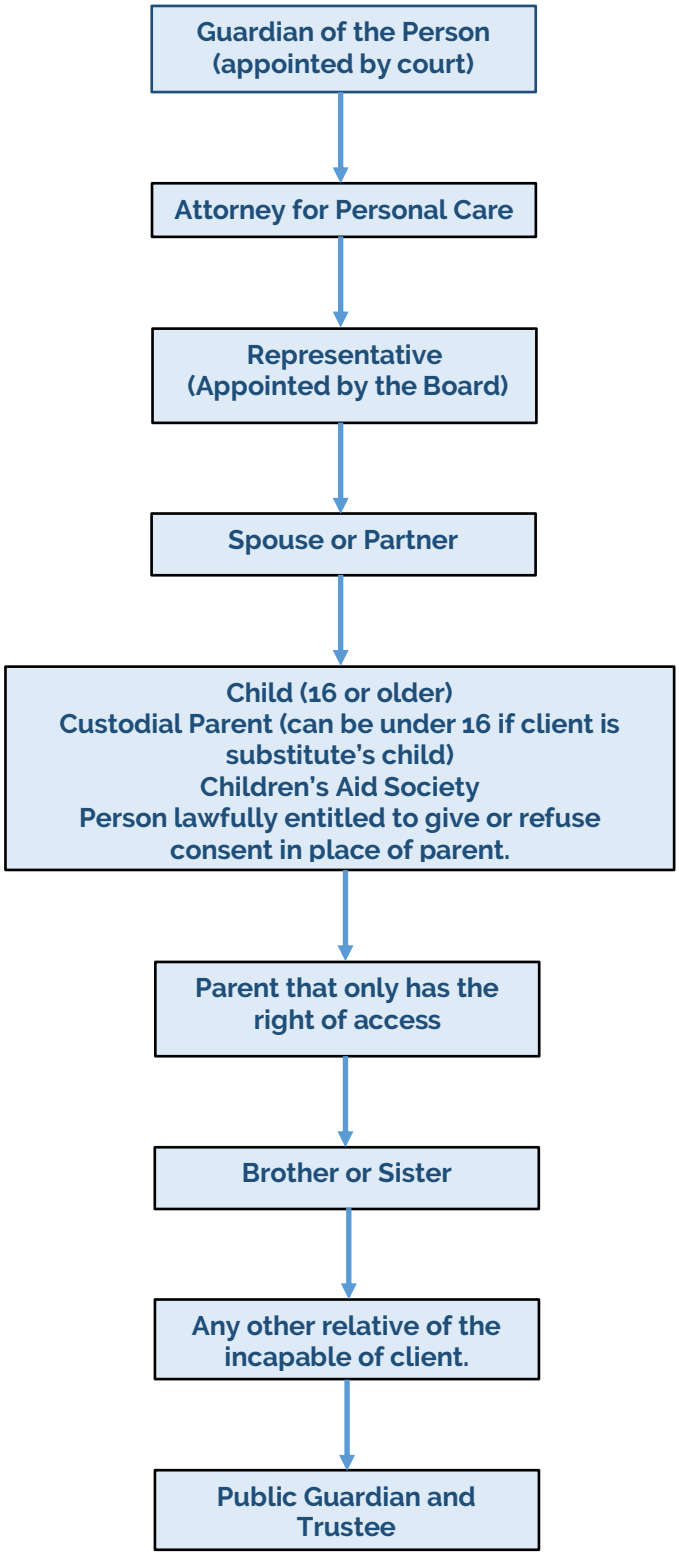
Protection from Liability

The *HCCA* protects midwives from being held liable for providing treatment if the midwife believed on reasonable grounds and in good faith, that the treatment was consented to. Likewise, midwives are protected from being held liable for not administering a treatment if the midwife believed on reasonable grounds and in good faith, that the treatment was refused.[39]

Midwives are also protected from providing treatment or not providing treatment in emergency circumstances, if they acted in good faith.[40]

[36] *Ibid*, s. 25(8).
[37] *Ibid*, s. 27(a)(b) and 21.
[38] *Ibid*, s. 21(2)(a)(b)(c)(1. – 4.)
[39] *Ibid*, s. 29(1) and (2).
[40] *Ibid*, s.29(4) and (5).

Appendix "A" – Hierarchy of Substitute Decision Makers



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