Consent to Health Care Policy

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1.0 Introduction

1.1 Description

This document is a resource for health care providers across Providence Health Care (PHC) to provide guidance on obtaining, validating and documenting consent for health care, including blood transfusion and mental health, for patients and residents, whether adults or minors.

The policy has been written with consideration to the relevant legislation and current "best practices" from a risk management perspective where legislation is silent.

1.2 Scope

This policy applies to all individuals providing health care to PHC patients with no exceptions.

2.0 Policy

Policy statement

Every capable patient has the right to:

- Give, refuse, or revoke consent to health care on any grounds, including moral or religious grounds, even if refusal will result in death;
- Expect that a decision to give, refuse or revoke consent will be respected;
- Be involved to the greatest degree possible in all care planning and decision-making.

Except in exceptional circumstances as described in this policy, a valid consent must be obtained before any health care is provided.

Consent is considered valid if it is given by a capable adult patient and it is:

- Specific to the health care proposed;
- Given voluntarily;
- Not obtained through misrepresentation or fraud; and
- Informed.

2.1 Capacity

All patients are presumed to be capable of making decisions about their health care until the contrary is demonstrated.

If the patient's capability is in question, the health care provider must assess the patient to determine whether or not the patient demonstrates an understanding of the information provided about the

nature, consequences and alternatives of the proposed health care; and that the information applies to the patient's own situation. The provider must document the observations that form the basis for the assessment in the health record.

If an adult patient is deemed incapable of making a consent decision, consent is obtained through an authorized Substitute Decision Maker ("SDM").

There is no minimum legal age of consent in British Columbia. If consent is required from a minor (< 19 years of age) the case must be assessed individually on the basis of the minor's capacity to understand. If the minor patient is deemed incapable or providing consent, consent is obtained from a parent or legal guardian.

2.2 Scope of Consent

Consent to health care applies only to the specific health care, including a course of treatment, to which a patient has consented. If the health care changes significantly, or if new health care issues arise, a new consent is obtained.

A health care provider may provide additional or alternative health care without a new consent if:

- the health care that was consented to is in progress;
- the person is unconscious or semi-conscious; and
- it is medically necessary to provide additional or alternative health care to deal with conditions not foreseen when consent was given.

If a plan of treatment is proposed, one health care practitioner who is able to answer the patient's questions about all aspects of the treatment may, on behalf of all the health care practitioners involved in the plan of treatment, propose the treatment, assess capacity and complete the consent process.

2.3 Duration of consent

Consent for health care is valid:

- until it is revoked;
- until there is a change in the patient's health status;
- until there is a change in the health care provider's knowledge which may affect the original consent, or
- for a period of one year. If a year has passed since consent was obtained, the health care provider should re-affirm the patient's condition and document the fact of continued consent by initialling and dating the health care consent form, or obtaining a new consent.

Consent for health care from a Temporary Substitute Decision Maker (TSDM) is valid for 21 days. However, if the course of treatment lasts longer than 21 days, consent remains valid until treatment is complete.

2.4 Documentation of Consent Decision in Acute Care

2.4.1 Documentation Required

Documentation of a consent decision is required in the following situations:

- Blood products – Any administration of fractionated or non-fractionated blood products (based on the recommendations of the Canadian Society for Transfusion Medicine);
- Any procedure or course of treatment meeting one of the following criteria:
  - Involving procedural sedation or general anaesthetic
  - As determined as a standard within a particular program setting.
- Any procedure or course of treatment for which the provider has reason to believe that documentation is warranted, both as a communication tool and also as a means for managing risk in the event of an adverse event;
- Research or experimental care.

All Health Care Providers are encouraged to document in the patient's health record the discussions that took place as part of the informed consent process.

2.4.2 Witnessing consent

Whenever possible, the Most Responsible Provider ("MRP") who obtains consent should witness the patient's signature on the consent form. If the MRP is unable to witness the signature, another health care provider may sign as a witness. In those circumstances, the witness is only confirming that it was the patient who signed the form. They are not witnessing the informed consent discussion.

2.4.3 Use of PHC Forms

If a consent decision requires documentation, the PHC consent form (PHC# MR002) must be used. However, chart notation by the Health Care Provider of the consent decision is acceptable in exceptional circumstances (e.g. when forms are not readily accessible). The chart notation should include the scope of discussion and the decision of the patient/resident.

All relevant blanks on the form are to be completed. Alterations to the form are permitted, but must be initialed by the patient/resident to be considered valid. Abbreviations should be avoided.

If the treatment is to be performed under the auspices of PHC but the consent decision is obtained in the Health Care Provider's office, the form is completed in the Health Care Provider's office and sent to the appropriate department for inclusion in the health record.

Consent for care provided at a PHC facility MUST be on a PHC form. The use of a Vancouver Coastal Health Authority consent form for care provided at PHC is not permitted.

The identity of an SDM must be documented on an Identification of Substitute Decision Maker Form (PHC# MR081).

2.5 Documentation of Consent Decision in Residential Care

On admission, the nature of the care to be provided in the facility is explained, and then the resident signs the Residential Care: Consent for Treatment form.

When the care plan is developed, the resident is required to provide consent to the treatment contained in the plan. Consent to the care plan, or the refusal to provide consent, is documented in the resident's Health Record. Refer to Policy CPF1100 – Options for Care for further information on obtaining informed consent for residential care admissions.

2.5.1 Consent Exceptions

Consent is not required in the following circumstances:

Emergent/Urgent Treatment

In the case of an emergency a health care provider may provide health care without consent. An emergency is defined as care necessary to preserve a patient's life, prevent serious physical or mental harm or alleviate severe pain. If the health care could be delayed without repercussion to the patient then it is not an emergency and consent must be obtained.

Emergent or urgent health care may also be provided when:

- The patient is unconscious or impaired by drugs or alcohol and is unable to give consent; and
- There is no substitute decision maker available.

Where practical, a second health care provider should confirm the incapacity of the patient and the need for health care.

In the case of an emergency, the health care provider must respect any advance directive available, or be guided by an available degree of intervention document, out-of-province "proxy health care directive" or DNAR order. If a Health Care Provider has reasonable grounds to believe that an adult, while capable, expressed a relevant instruction to refuse consent to certain health care, a Health Care Provider must not provide that health care, even in an emergency.

Continuing efforts should be made to get consent from the patient directly, or from a substitute decision maker, even after the health care has been initiated.

Emergent/urgent treatment without consent is to be documented on the consent form (Form # PHC – MR002).

Preliminary examination, treatment of diagnosis

A health care provider may undertake triage or another kind of preliminary examination, treatment or diagnosis of an adult without obtaining an informed consent decision if:

- The adult indicates that he or she wants to be provided with health care, or
- In the absence of an indication by the adult, the adult's spouse, relative or friend indicates that he or she wants the adult to be provided with health care.

Involuntary Psychiatric Care

Certified patients may or may not be competent to consent to psychiatric care and treatment. The Director of the Mental Health Program is authorized by the *Mental Health Act* to override the refusal of a certified patient and consent to involuntary psychiatric treatment on the patient's behalf.
http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96288_01#section22

Certified psychiatric patients may or may not be competent to consent to non-psychiatric care. The Director of the Mental Health Program is not authorized to consent to non-psychiatric health care treatment unless the health care is necessarily collateral to the psychiatric care. If the patient is not competent to make non-psychiatric health care decisions, the health care provider must obtain consent from an authorized Substitute Decision Maker.

Communicable Disease

Under the authority of the *Public Health Act Communicable Disease Regulations* (http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/12_4_83), treatment of patients with certain communicable diseases is compulsory and requires no consent. Please consult with the Medical Microbiologist or Risk Manager if you have any questions about treatment of communicable disease.

2.6 Telephone consent

Consent by telephone is not to be used for the convenience of the family or the hospital. Under unusual circumstances, where the substitute decision maker is at some distance, or in an emergency, it is permissible to obtain telephone consent as follows:

a. A telephone with a conference call feature is ideal if available, so that the health care provider, the substitute decision maker and a third party who will verify that consent was obtained can participate simultaneously.

b. The substitute decision maker is telephoned by the health care provider and made aware that another person is on the line.

c. The Health Care Provider explains the nature of the proposed treatment, expected benefits, material risks and side effects and health consequences of not having the treatment. Questions from the substitute decision maker are answered.

If a written consent is required, the wording in the consent form is dictated to the substitute decision maker and consent is obtained. The **Telephone Consent Declaration** on the back of the consent form must be completed.

NOTE: If the conference call feature is not available, the third party should verify with the substitute decision maker the nature of the conversation that took place and confirm that consent has been given for the proposed treatment

2.7 Compliance

Failure to comply with this policy is a serious infringement on the rights of patients and may result in disciplinary action and/or legal consequences.

3.0 Procedure

1. Assess patient

2. Determine what care/treatment is recommended

3. Discuss recommendations with patient, providing information on:

   a) their condition,
   b) risks and benefits of obtaining treatment,
   c) risks and benefits of foregoing treatment,
   d) alternatives to proposed treatment; and
   e) any question the patient asks (see Appendix A).

4. Determine if there is a properly executed Advance Directive to guide the health care. If patient is incapable and there is an Advance Directive, follow the Advance Directive;

5. If patient is incapable and there is no Advance Directive, or the Advance Directive is not relevant to the care required, seek a Substitute Decision Maker ("SDM") (see Appendix B);

6. Document consent when required/indicated;

7. Initiate treatment.

3.1 Responsibilities

Responsibility for obtaining informed consent rests with the Most Responsible Provider proposing or performing the care. This is both a professional obligation and a legislated duty imposed on the health care provider and cannot be delegated. However, every health care provider has a responsibility to ensure that a consent decision is in place before providing care, and to advise the Most Responsible Provider if consent has not been obtained or if concerns arise as to the validity of a consent decision.

For clarity of communication among members of the heath care team, the Most Responsible Provider must ensure accurate and timely documentation of the consent decision in accordance with this policy.

4.0 Supporting Documents and References

4.1 Related Policies

CPV0700 Disclosure of Serious Patient Safety Incidents
CPF1100 Options for Care
CPF2600 Advance Care Planning/Serious Illness Conversations Policy
CPF0600 Death

4.2 Related Standards / Forms / Guidelines

PHC MR031 Consent Form
PHC MR081 Identification of Substitute Decision Maker form

PHC MR030	Consent for Transfusion of Blood and/or Blood Products
PHC AD066	Consent for Jurisdiction of Treatment form
PHC MR032	Consent for Photography and Audiovisual Recording
PHC LA 137	Consent for Autopsy form

4.3 Definitions

Advance Care Planning is the process of a capable adult talking over their beliefs, values, and wishes about the health care they wish to consent to or refuse, with their health care provider and/or family, in advance of a situation when they are incapable of making health decisions.

Advance Directive provides written consent to (or refusal of) health care to a health care provider in advance of a decision being required about that care. Advance directives must be written, signed by a capable adult, and witnessed by two witnesses (or one witness who is a lawyer or notary public). A witness cannot be a person who provides personal care, health care, or financial services to the adult for compensation, nor the spouse, child, parent, employee, or agent of such a person. An Advance Directive that adheres to these requirements is referred to in this document as "properly executed".

A properly executed Advance Directive is considered to be legally binding in British Columbia.

Emergency/Urgent Care is care that is immediately necessary in order to save life, prevent serious physical or mental harm or to alleviate severe pain.

Health Care means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health, and includes:

a. A series or sequence of similar treatments or care administered to an adult over a period of time for a particular health problem; or

b. A plan for health care that is developed by one or more health care providers and deals with one or more of the health problems that an adult has or is likely to have in the future.

Informed Consent includes receiving information that a reasonable person in the same circumstances would require, including:

a. The nature of the treatment;
b. The expected benefits of the treatment;
c. The material risks of the treatment;
d. The material side effects of the treatment;
e. Alternative courses of action;
f. The likely consequence of not having the treatment; and
g. Any information the patient/resident specifically requests.

Most Responsible Provider is the person who has the overall responsibility for the management and coordination of the care of the patient at any given time.

Patient: For the sake of readability, reference is made to the "patient" throughout this policy. Unless otherwise directed, any reference to "patient" should be interpreted to mean patient, client and/or resident.

Substitute Decision Maker: If an adult is determined to be incapable of making a consent decision, consent must be obtained from a properly executed Advance Directive or from someone on the patient's behalf. The person making decisions on behalf of a patient is called a "substitute decision maker". Please see Appendix B for further clarity.

4.4 References

Public Health Act Communicable Disease Regulations, (BC Reg. 4/83)
Health Care (Consent) and Care Facility (Admissions) Act, RSBC 1996, c. 181
Human Tissue Gift Act, RSBC 1996, c. 211
Infants Act, RSBC 1996, c. 223
Mental Health Act, RSBC 1996, c. 288
Patients Property Act, RSBC 1996, c. 349
Representation Agreement Act, RSBC 1996, c. 405

4.5 Keywords

Informed; consent; TSDM; substitute decision maker; advance directive; jurisdiction; organ; placebo

4.6 Appendices

A – Requirements for Consent
B – Substitute Decision Makers
C – Autopsy
D – Special Consent Situations

4.7 Questions

Contact: Risk Management

Appendix A: Requirements for Consent

Elements

Whether the consent is verbal or written, consent must incorporate the following five elements:

- The patient is capable of giving or refusing consent;
- The consent is specific to the health care proposed;
- The consent is given voluntarily;
- The consent is not obtained through misrepresentation or fraud; and
- The consent is informed.

An informed consent includes receiving information that a reasonable person in the same circumstances would require, including:

- The nature of the treatment;
- The expected benefits of the treatment;
- The material risks of the treatment;
- The material side effects of the treatment;
- Alternative courses of action;
- The likely consequence of not having the treatment; and
- Any information the patient/resident specifically requests.

Assessing Capability

Every patient is presumed competent to consent to or refuse health care unless/until there is evidence to the contrary. A health care provider must communicate with the patient in a manner appropriate to the patient's skills and abilities to help him/her demonstrate understanding of the information.

Recommended guidelines for informally determining the patient's capability include evidence that the patient is able to demonstrate understanding of the information by:

- Repeating and explaining the health care in their own words;
- Providing clear, consistent and unambiguous answers to questions about the health care;
- Demonstrating an understanding of the consequences of authorizing or not authorizing the treatment;
- Asking pertinent questions to indicate an understanding; and
- Demonstrating that he/she understands that the information being provided pertains to their own situation.

A patient may be capable with respect to some treatments and incapable with respect to others (e.g. a mildly cognitively impaired patient may not be able to make a consent decision about abdominal surgery but may be able to consent to suturing of a laceration).

A patient incapable with respect to treatment at one time may be capable at another (e.g. patient admitted to Emergency for severe alcohol intoxication may not be able to make decisions about the immediate treatment, but after a period of time they may regain ability to assess information and make decisions about ongoing care).

Where there is a difficult judgment or dispute over a patient's capability, a psychiatrist or other qualified health care provider may be asked to examine the patient to make a determination.

Whatever the decision, it is important that the Health Care Provider who is proposing the health care document the observations that form the basis of his/her determination of capability.

If an adult is incapable, consent must be obtained from the Substitute Decision Maker.

Voluntariness

Consent must be voluntary. Coercion or undue influence will invalidate consent. If a health care provider is concerned that consent was given because the patient felt fearful of the reaction from others (either family and friends or the health care providers), the health care provider must take steps to ensure that the decision accurately reflects the patient's wishes.

A consent obtained under false pretenses is also invalid. This issue most often arises in cases of placebo therapy. A deliberate misrepresentation (as to procedure or outcome) from the health care provider for the purposes of obtaining consent will invalidate consent.

It is preferable to obtain consent prior to the administration of any sedation. If sedation has been given and it is discovered that there is no informed consent, the health care provider cannot proceed unless confident that the effect of the sedation has not adversely affected the patient's ability to understand the basic nature of the contemplated procedure.

Appendix B: Substitute Decision Makers

Until the contrary is demonstrated, every adult is presumed to be capable of giving, refusing or revoking consent to health care. If a decision is made that an adult is incapable of making a consent decision, consent must be obtained from a properly executed Advance Directive or from someone on the patient's behalf. The person making decisions on behalf of a patient is called a "substitute decision maker" ("SDM").

The Adult Guardianship legislation sets out a ranked list of SDMs who can make health care decisions on a patient's behalf:

1 Committee
2 Representative under a Representation Agreement
3 Temporary Substitute Decision Maker

Please note that the authority of a Power of Attorney relates to financial matters only, and does not convey the right to make health care decisions.

In order to improve communication between members of the health care team, the identity of the SDM is documented on an Identification of Substitute Decision Maker Form (# PHC-MR081).

1. Committee

Under the *Patient's Property Act* the Supreme Court of British Columbia may have appointed a "Committee" for an adult who is incapable of making health care decisions. This would commonly be seen in the case of adults with severe mental disabilities, who would never have had an opportunity to plan in advance for their own care.

If the patient has a Committee, complete the Identification of Substitute Decision Maker form, obtain a copy of the Committee's appointment and place them both in the Health Record as verification of the appointment.

2. Representative

An adult may have planned for their future by making a Representation Agreement under the *Representation Agreement Act*.

A Representation Agreement is used if a capable adult wants to name a specific adult to make decisions on their behalf (when they are not capable of making those decisions themselves). The Representative is authorized to act within the authority given in the Representation Agreement.

There are two levels of Representation Agreements. Section 7 agreements are used to authorize a representative to make health care, personal and financial decisions but MAY NOT be used to help make, or to make on the adult's behalf, a decision to refuse health care necessary to preserve life or to physically restrain, move or manage the adult, or authorize another person to do these things. Adults who are not capable of making a section 9 agreement may be able to make a section 7 agreement.

Section 9 agreements have wider scope than section 7 agreements and the representative may be authorized to make health care and personal decisions (not financial) that include giving or refusing consent to health care necessary to preserve life.

The Representative must consult to the greatest extent possible with the adult to determine her/his wishes and comply with those. When current wishes are not known, the Representative must comply with instructions or wishes the adult gave while capable. If not known at all, then they must act on the basis of the patient's beliefs and values, and if those are not known, then in the adult's best interests.

If an adult has both a Representation Agreement and an Advance Directive, then the Representative must make decisions based on the adult's Advance Directive. If the Representation Agreement specifically states that a health care provider may act on an Advance Directive without consent of the adult's representative, then the health care provider may do so.

If possible, a copy of the Representation Agreement should be placed on the patient's health care record with a completed Identification of Substitute Decision Maker form as verification of the appointment.

3. Temporary Substitute Decision Maker (TSDM)

If there is no Committee appointed, and no Representation Agreement that refers to the particular health care situation in place, the health care provider must choose the nearest individual who qualifies to make a health care decision. Confirmation of the person selected as the TSDM is documented on the Identification of Substitute Decision Maker form. The TSDM is asked to sign the form to reinforce the duties associated with this role. However if the TSDM is unavailable the form is still considered complete without their signature.

If a TSDM is initially contacted via telephone, please follow the procedure for completing the Identification of Substitute Decision Maker Form as described under Telephone Consent.

The health care provider chooses the person who is highest on the following list to be the TSDM:

a. the adult's spouse (including same-sex partner living in a marriage like relationship);
b. the adult's child;
c. the adult's parent;
d. the adult's brother or sister;
e. the adult's grandparent,
f. the adult's grandchild,
g. anyone else related by birth or adoption to the adult,
h. a close friend of the adult, or
i. a person immediately related to the adult by marriage.

The *Health Care (Consent) Act* requires that the TSDM meet certain criteria in order to be entitled to make decisions. The TSDM must:

a. be at least 19 years of age
b. have been in contact with the adult in the preceding 12 months
c. have no dispute with the adult
d. be capable, and
e. be willing to comply with the duties of a TSDM

In the rare case that there is NO ONE available to act as a TSDM from the above list, the matter is referred to the Public Guardian and Trustee who will appoint someone from their office to act as the TSDM.

Decisions on behalf of the adult to consent or refuse treatment will be made in accordance with the following guidelines:

a. known applicable instructions or wishes made by the adult when capable are to be followed. Applicable instructions in the form of an Advance Directive may be followed without referring to the TSDM;

b. if there are no known prior capable instructions or wishes, the decision is to be made in accordance with known applicable values and beliefs;

c. if there are no such known values and beliefs then a decision is to be made in the adult's best interests, considering:

- the adult's current wishes
- the likely effect of receiving or not receiving the proposed health care
- the expected benefits, weighed against the risk of harm, and
- whether there are less restrictive or less intrusive alternatives that would be as beneficial

Authority of the TSDM

A TSDM has the authority to:

a. Give or refuse substitute consent for a period of 21 days from date chosen,
b. If signed within a 21 day period, give or refuse consent for a course of treatment that will last longer than 21 days, and
c. Review the information necessary to make an informed decision about the proposed health care treatment (this includes access to areas of the chart relevant to the condition for which the treatment is proposed).

Restrictions on a TSDM

A TSDM can refuse consent for care necessary to preserve life only if there is substantial agreement of health care providers that this is medically appropriate, and if the decision would appear to reflect the patient's pre-expressed instructions, values, or best interests.

A TSDM cannot give consent to the following procedures:

a. Abortion unless recommended in writing by the treating physician and at least one other medical practitioner who has examined the adult from whom it is proposed;
b. Electroconvulsive therapy unless recommended in writing by the treating physician and at least one other medical practitioner who has examined the adult for who it is proposed;
c. Psychosurgery;
d. Removal of tissue from a living human body for implantation in another human body or for medical education or research;
e. Experimental health care involving a foreseeable risk that is not outweighed by the expected therapeutic benefit;
f. Participation in a health care or medical research program that has not been approved by the PHC Research Ethics Board;
g. Any treatment, procedure or therapy that involves using aversive stimuli to induce a change in behaviour.

A TSDM may be, but is not necessarily, the person entitled to give consent for autopsy.

The Health Care Provider may in emergency situations provide health care contrary to directions given by a Substitute Decision Maker if the Health Care Provider is of the opinion that the Substitute Decision Maker is not following the previous instructions or wishes of the patient.

In the event a Health Care Provider is concerned that a Temporary Substitute Decision Maker is making a decision in contravention of an adult's wishes, a new Temporary Substitute Decision Maker may be selected (compliance with the wishes of the adult expressed when capable is a requirement to be a Temporary Substitute Decision Maker).

Resolution of Objections to Decisions Made by Authorised Substitute Decision Makers

A patient has the right to be informed when a decision is made to delegate consent decisions to a substitute decision maker. If the patient or a friend or family member disagrees with the substitute consent decision, the "objector" may contact the care team to determine how that decision will be reviewed.

Most conflicts can be resolved through the use of informal means. Resources available to assist in resolution include staff from Client Relations, Ethics and Risk Management if required.

If informal resolution is not possible, the objector should be advised of their right to advise the Public Guardian and Trustee of their concerns about decisions made by the substitute decision maker. The Public Guardian and Trustee will consider any evidence that demonstrates that the substitute consent decision is made against the patient's known wishes, or is not in the patient's best interests.

If the objector is still dissatisfied with the consent decision made, they should be instructed to retain Counsel in order to seek Court intervention (Risk Management should be advised as soon as possible.)

If you have more questions, the website of the Public Guardian & Trustee provides a wealth of useful information. www.trustee.bc.ca

Appendix C: Autopsy

An autopsy is anticipated in the following circumstances:

- As outlined in the *Coroner's Act*
- On request of the Attending Physician with consent from the family
- On family request

Coroner's Cases

Notification to the Coroner is required when a health care provider has reason to believe that the patient died:

a. as a result of violence, accident, negligence, misconduct or malpractice,
b. as a result of a self-inflicted illness or injury,
c. suddenly and unexpectedly, when the person was apparently in good health and not under the care of a medical practitioner,
d. from disease, sickness or unknown cause, for which the person was not treated by a medical practitioner,
e. during pregnancy, or following pregnancy in circumstances that might reasonably be attributable to pregnancy,
f. if the chief coroner reasonably believes it is in the public interest that a class of deaths be reported and issues a notice in accordance with the regulations, in the circumstances set out in the notice
g. while a patient of a designated facility or private mental hospital within the meaning of the *Mental Health Act*, whether or not on the premises or in actual detention,
h. while the person is committed to a correctional centre, youth custody centre or penitentiary or a police prison or lockup, whether or not on the premises or in custody, or
i. while a patient of a hospital within the meaning of the *Hospital Act*, if the patient was transferred to the hospital from a place referred to in paragraph (g) or (h).

The *Coroner's Act* authorizes the Coroner to order an autopsy without the family's consent.

Non-Coroner's Cases

The most responsible provider is required to obtain consent for a non-coroner's case autopsy. The individual entitled to consent to autopsy is determined by the *Cremation, Interment and Funeral Services Act* **and is not necessarily the same individual entitled to make consent decisions while the patient was alive**.
http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_04035_01

The physician obtains consent from the following in descending order of authority:

a. The personal representative (i.e. executor) named in the will of the deceased. If this person is not readily known and available at the time of the consent discussion, health care providers may proceed to the nearest relative as set out below;
b. The spouse of the deceased, including common law spouse or partner of the same gender, if living with the deceased for a period of at least two years immediately before the death of the deceased;
c. An adult child of the deceased;
d. An adult grandchild of the deceased;
e. If the deceased was a minor, the legal guardian at the date of death;

f. A parent of the deceased;
g. An adult brother or sister of the deceased;
h. An adult niece or nephew of the deceased;
i. An adult person having some family relationship with the deceased;
j. An adult person having some relationship with the deceased not based on blood ties or affinity;
k. If none of the foregoing is available, contact the Coroner for discussion of options.

The physician may rely on the word of the person stating their relationship unless there is some reason to doubt that attestation.

Written consent for or refusal of autopsy is required on the Consent for Autopsy form (PHC-LA 137).

Appendix D: Special Consent Situations

Adoption

In accordance with the *Adoption Act*, the authority to give consent remains with the biological mother until she has:

- In writing transferred 'care and custody' of the child to the Director (Ministry of Children and Family Development), or the administrator of an adoption agency; or
- Consented to adoption, at which time the Director or the administrator of an adoption agency becomes the guardian of the child, and authorized to make consent decisions. However, if the adopting parents wish to delay adoption procedures while health care is provided, the authority for consent remains with the biological mother unless 'care and custody' of the child has been transferred to someone else.

http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96005_01

Advance Directives

An Advance Directive contains a person's instructions (consent or refusal) in respect of health care treatments that are to be followed in the future, and they become effective in situations where the adult is no longer capable of making health care decisions. Advance directives, in the proper form, are considered legally binding in British Columbia.

Communication challenges

It is the goal of Providence Health Care to ensure that the best possible interpretation services are provided for every patient utilizing our services. In many cases, the best possible translation service will require the use of a medical interpreter. However, with regard to logistics, care requirements and timeliness a professional translator may not always be possible.

If a patient's understanding of English is in doubt then the health care provider **must** ensure that an interpreter is used during the **consent** process. Every attempt should be made to ensure that the skill level of the interpreter is appropriate for the complexity of the situation.

- Staff are encouraged as much as possible to utilize the services of a **medical interpreter** when major health care decisions are being made (for example: surgical procedures, radiation therapy, chemotherapy, DNAR decisions or options for care).

- Friends or family members often do not have the understanding or vocabulary to interpret clinical issues, and may find it difficult to translate frank information to their loved one, so should only be used as interpreters for major health care decisions at the patient's and family's request.

- As the interpretive skill of bilingual staff is completely unknown the use of staff as untrained interpreters is discouraged.

When a medical interpreter is used for consent, the interpreter will witness the consent form, indicating that the consent process was interpreted to the patient. The patient signs the form in the interpreter's presence, acknowledging that they have been informed about the procedure and that all questions have been answered.

If interpreter services are provided via telephone, please follow the procedure for completing the Consent Form as described under Telephone Consent.

Interpreting Service is available 24/7 at this link.

Involuntary Admission

Under the *Mental Health Act* an adult may be admitted and provided mental health treatment without their consent if all four of the following criteria apply:

- The patient is suffering from a mental disorder that seriously impairs their ability to react appropriately to their environment or to associate with others;
- The patient requires psychiatric treatment in a designated facility (St. Paul's Hospital is a designated facility);
- The patient requires care, supervision and control in a designated facility to prevent substantial mental or physical deterioration or for their own protection or the protection of others; and
- The patient is not suitable as a voluntary patient.

One Form 4 Medical Certificate is required to provide legal authority for an involuntary admission for a 48-hour period. A second Medical Certificate by a different physician must be completed within 48 hours of admission, otherwise the patient must be discharged or admitted as a voluntary patient. Once the second Medical Certificate is completed the person may be admitted as an involuntary patient for up to one month from the day of initial admission.

To obtain consent for health care **not related** to mental health treatment from patients who are involuntarily admitted, follow the same process and procedure as that for other patients. Patients under 16 years of age admitted under the *Mental Health Act* are admitted involuntarily with the consent of their parent or legal guardian. In this case, the parent or legal guardian is the person able to give consent.

Further detailed information on this topic is available at:
http://www.hlth.gov.bc.ca/mhd/pdf/MentalHealthGuide.pdf

Non-readers/writers

If a patient cannot read the consent form, the health care provider obtaining consent must read the form aloud to the patient. In place of a signature the patient may make a mark on the form that will be recognised as their identifier. The health care provider should write a note to this effect on the consent form.

A patient who is unable to make a mark on the consent form due to a physical impairment should indicate verbal agreement to the treatment in the presence of two witnesses. The witnesses will sign the consent form on behalf of the patient, and indicate on the form that the patient was unable to sign due to physical impairment.

Non-Residents of Canada

Patients identified as non-residents of Canada are asked by the admitting clerks to review and sign the Consent for Jurisdiction of Treatment form on admission. By signing the form the non-resident patient agrees that, if they are dissatisfied with their care, they will pursue litigation in the BC courts rather than the courts of their home jurisdiction.

The Consent for Jurisdiction of Treatment form (Form # PHC – AD066) is available from Printing in English, Chinese, French, Korean, Punjabi and Vietnamese.

Failure or refusal to sign the form should not result in denial to render care in an urgent/emergent situation. However PHC may choose to deny care to a patient seeking elective treatment who refuses to sign this form.

Organ and Tissue Donation

Please see CPF0800

Photographs and other recordings

No photo, video, sound recording ("Recordings") or any other image of a patient may be made without the express consent of the patient unless:

- The patient will not be identified or identifiable in any way as part of the Recording; or
- The Recording is made expressly and solely for the care of that patient (and for which consent has been obtained as part of the procedure).

Consent for photographs and interview materials for the purposes of publicity are to be documented on Form No. PHC-MR032.

Consent for photographs, videos, sound recordings or any other images for the purposes of educational, scientific or research purposes are to be documented on Form No. MR033. Custody and control of the recorded image will be with Providence Health Care unless arrangements are made to the contrary.

Patients and their families are entitled to have recordings made at their own expense and under their own direction. However, it is important that no other patients or visitors be included in these recordings. Staff are permitted to participate in these recordings to the extent that they are comfortable.

Placebo Medications

No health care provider will provide a placebo medication to a patient without the patient's written consent. Please see Corporate Policy CPF1400: Placebo Medications