

# Determining capacity to consent

## Guiding physicians through capacity and consent to treatment law



### THIS GUIDE WAS DEVELOPED BY:

The Mini Task Force on Capacity Issues,  
The Dementia Network of Ottawa

### MEMBERS OF THE MINI TASK FORCE:

Michele Tremblay, FRCPC, Director of the Inpatient  
Geriatric Unit, Royal Ottawa Hospital

Linda Gobessi, MD, FRCPC, Geriatric Psychiatry  
Community Services of Ottawa

Trudy Spinks, LLB, Deputy Public Guardian and  
Trustee/Client Services

Sanjay Srivastava, LLB, Regional Vice-Chair, Ontario  
Consent and Capacity Board

Clarissa Bush, PhD, C Psych, Memory Disorder Clinic  
SCOHS

Lyla Graham, MD, CCFP, Family Physician, Ottawa,  
Ontario

Ian Richardson, MD, CCFP, Family Physician, Ottawa,  
Ontario

The College's Complaints Committee has identified certain issues that appear to be recurring areas of misunderstanding or difficulty for members of the medical profession. One such area is the issues involved in determining capacity to consent in the cognitively impaired.

From time to time, the Committee deals with complaints against physicians who have misunderstood the law with respect to assessing capacity or making decisions without appropriate consents, particularly in circumstances of cognitively impaired patients in nursing home settings, or those who have disinterested or feuding family members. It is easier to misstep in these situations if one is not familiar with the process.

The College has developed a policy to help physicians better understand issues around consent. The policy is called Consent to Medical Treatment (available under Policies at [www.cpso.on.ca](http://www.cpso.on.ca)).

To further provide guidance to physicians, we are publishing here an abridged guide to capacity and consent issues, adapted from "A Practical Guide to Capacity and Consent Law of Ontario for Health Practitioners Working with People with Alzheimer Disease" published by the Dementia Network of Ottawa.

In the September issue of *Dialogue*, we will publish guidance in determining Capacity to Consent to Admission to a Care Facility.

### Introduction

Progressive dementias ultimately interfere with decision-making abilities involved in all aspects of life. As there is no uniformity in the illness progression, specific capacities will be lost at different periods during the course of each person's disease. Each of these unique capabilities requires distinct abilities and skills, and must be assessed independently. Physicians may encounter individuals needing assessment of capacity to make a will, to marry, to drive, to consent to treatment, to consent to

### Editorial note:

This article was prepared for health practitioners working with Alzheimer Disease to provide guidance for the law relating to consent and capacity for consenting and refusing treatment. It is not an exhaustive review of advance care planning. Physicians should note that other legal obligations may flow from a finding of incapacity to consent to treatment, particularly if the finding is made while the patient is admitted to a psychiatric facility. Physicians are also obliged to ensure that, when seeking consent from a substitute decision-maker, the substitute decision-maker is aware of the principles of substitute decision-making set out in section 21 of the Health Care Consent Act, 1996. Physicians should take care to record the details of the assessment leading to a finding of incapacity and the reasons therefor. When in doubt, seek the advice of counsel or other legal resources.

admission to a care facility, etc. Some of these assessments require special knowledge and understanding of the provincial legislation to manage and protect the incapable individual. All of the relevant Ontario Acts cited are available at [www.e-laws.gov.on.ca](http://www.e-laws.gov.on.ca).

Although the law views one as either capable or incapable with respect to a specific task, it is important to note that the level of capacity may fluctuate. In some individuals this fluctuation may be marked and capacity may need to be assessed more than once. The ultimate aim is to preserve the person's autonomy as long as possible while ensuring that his or her vulnerability is protected. Removing one's decision-making capacity has significant repercussions for the person as well as for his/her caregivers. In general, the Ontario legislation encourages that the least restrictive approach be taken.

## Capacity to Consent to Treatment

**Why is capacity to consent to a treatment an important issue for physicians working with people with dementing illness?**

In Ontario, the *Health Care Consent Act (HCCA)* governs health practitioners including physicians. This legislation states that for a treatment to be administered to a person, informed consent is required, either from the patient if mentally capable, or, if not, from a legally authorized substitute decision-maker. The only exception to this involves emergency care. Due to the progressive deterioration in many dementing illnesses, people suffering from such illness are likely, at some point, to become incapable of making decisions regarding their treatment.

## What is the legal definition of capacity to consent to treatment?

*Health Care Consent Act* section 4 (1),

A person is capable of consenting to a treatment if the person is able to:

- a) "understand" the information that is relevant to making a decision about the treatment, and
- b) "appreciate" the reasonably foreseeable consequences of a decision or lack of decision.

A person is presumed to be capable with respect to treatment unless reasonable grounds to suspect incapacity exist.

## How does dementia affect capacity to consent to treatment?

To consent to a treatment, one must be able to "understand" and "appreciate." To understand, the person needs to have the cognitive ability to remember the general information given regarding the proposed treatment. To appreciate, he or she needs the ability to weigh the information in the context of his or her life circumstances. In addition to memory, this requires the ability to reason and to make decisions. All of these abilities may be impaired in people with dementia.

## What can be done for someone who is likely to become incapable?

It is advisable to have a discussion with all patients in your practice, but particularly someone with a diagnosis of early dementia, about the importance of making a Power of Attorney for Personal Care under the *Substitute Decisions Act*. A discussion about the choice of attorney or attorneys can prevent misunderstandings or complications in the future. In the event that the person chooses not to sign a Power of Attorney for Personal Care, the physician can review who would be

the substitute decision maker under the *Health Care Consent Act*.

## Who is capable of giving a Power of Attorney for Personal Care?

A person is capable of giving a Power of Attorney for Personal Care if she or she,

- a) has the ability to understand whether the proposed attorney has a genuine concern for the person's welfare; and
- b) appreciates that the person may need to have the proposed attorney make decisions for the person.

A person who is capable of giving a Power of Attorney for Personal Care is also capable of revoking it.

## When does the Attorney for Personal Care make treatment decisions?

The Attorney for Personal Care makes treatment decisions only when the person becomes incapable with respect to the proposed treatment.

## Who assesses capacity to consent to treatment?

It is the health practitioner proposing the treatment who must assess whether the individual is capable of giving consent. A "health practitioner" is a member of one of the regulated health professions, including members of the College of Physicians and Surgeons of Ontario. A person is presumed to be capable with respect to treatment unless "reasonable grounds" to suspect incapacity exist. Incapacity may be suspected on the basis of direct observation of the person (e.g., the person is confused, disoriented, depressed, psychotic, extremely anxious, unable to make a decision, intoxicated, etc.) or from information obtained from family or other caregivers. ►►



## What is treatment?

“Treatment” means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic, or other health-related purpose and includes a course of treatment or plan of treatment. Given how broadly “treatment” is defined, it is fair to say that this legislation governs most interventions with patients. In fact in the CPSO’s policy, physicians are advised to obtain consent for all physician-patient interactions. For many of these interactions, a physician will be able to rely on implied consent. Nevertheless, treatment does not include assessment of a person’s capacity, the assessment or examination of a person to determine the general nature of the person’s condition, the taking of a person’s health history, communication of an assessment or diagnosis, treatment that in the circumstances poses little or no risk of harm and the use of physical restraints (this is regulated by common law and the *Patient Restraints Minimization Act*).

## When can physical restraints be used?

The *Patient Restraints Minimization Act* was introduced in 2001. It mandates hospitals and facilities to minimize the use of restraints including use of monitoring devices and confinement. Each hospital and facility establishes its own policies.

## The Mental Health

*Act* continues to govern the use of restraints in psychiatric facilities. However, neither Act affects the common law duty of a caregiver to restrain or confine a capable or incapable person when immediate action is necessary to prevent serious bodily harm to the person or others.

## What is “emergency” treatment?

According to the *Health Care Consent Act*, there is an “emergency” if the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm. It falls to the health practitioner to decide whether there is an “emergency.” Please note that an examination or diagnostic procedure that constitutes “treatment” may be conducted by a health practitioner 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 health practitioner, the person is incapable with respect to the examination or diagnostic procedure.

## What elements are required to obtain consent to treatment?

Consent must relate to the treatment, must be informed, must be given voluntarily and must not be obtained through misrepresentation or fraud. The health practitioner must have reviewed with the person the nature of the treatment, expected benefits, material risks and side effects, alternative courses of action and likely consequences of not having the treatment. Consent to treatment is informed, provided the person received information that a reasonable person in the same circumstances would require in order to make a decision about the treatment and the person received responses to his or her requests for additional information.

## How does one assess capacity to consent to treatment?

The health practitioner focuses on the person’s specific capacity in relationship to the proposed treatment. The person must be able to “understand” the information that is relevant to making a decision about the treatment and to “appreciate” the reasonably foreseeable consequences of a decision or lack of decision.

- Does the person understand the condition for which the specific treatment is being proposed?
- Is the person able to explain the nature of the treatment and understand relevant information?
- Is the person aware of the possible outcomes of treatment, alternatives or lack of treatment?
- Are the person’s expectations realistic?
- Is the person able to make a

decision and communicate a choice?

- Is the person able to manipulate the information rationally?

### What happens if the person is found incapable of consenting to the proposed treatment?

The person must be advised of his or her legal rights, unless the situation constitutes an emergency. In doing so, the health practitioner is expected to follow the guidelines developed by his or her own professional body, and in the case of physicians, the College's Consent to Medical Treatment policy ([www.cpsso.on.ca/Policies/consent.htm](http://www.cpsso.on.ca/Policies/consent.htm)).

- The physician must tell the incapable patient that a substitute decision-maker will assist the patient in understanding the proposed treatment and will be responsible for making the final decision.
- The physician should involve the incapable patient, to the greatest extent possible, in discussions with the substitute decision-maker.
- If the patient disagrees with the need for a substitute decision-maker because of the finding of incapacity, or disagrees with the involvement of the present substitute, the physician must advise the patient of his or her options. These include the finding of another substitute of the same or more senior rank, and/or applying to the Consent and Capacity Board for a review of the finding of incapacity.
- Physicians are expected to assist patients if they express a wish to exercise these options.

The information provided to the patient according to the policy ►►

## CAPACITY CONCERNS – CASE 1

Recently, a case came to the College's Complaints Committee as the result of a concern that Dr. B, a general practitioner, failed to conduct a proper capacity assessment on his elderly patient before advising her lawyers that she was no longer capable of managing her financial and medical affairs, and recommending that her Powers of Attorney regarding both personal care and property be put into effect.

The patient was physically impaired due to macular generation and arthritic knees. Because of concerns respecting falls, Dr. B referred the patient to a neurologist. The neurologist found the patient to be "vague." Dr. B's chart documents that in June 2000, the woman was exhibiting signs of "early dementia." Again in August 2000, the diagnosis of dementia was made.

On March 1, 2002, Dr. B wrote to the patient's lawyers, recommending that the patient's step-daughter have Power of Attorney regarding personal care and property for the patient and her husband. At that point, Dr. B had not seen the patient since November 10, 2001.

When Dr. B next saw the patient, it was at her home on March 21, 2002, the day of her husband's funeral. The next day, he wrote her lawyers recommending that the step-daughter utilize the Powers of Attorney due to the patient's physical and psychological deterioration and because she was unable to manage her affairs "both legally and mentally."

The patient's sister-in-law stated that on April 9, 2002, she and her husband took the patient to visit the lawyer, and that it was "obvious" at that time that the patient was competent. The patient's brother wrote Dr. B a letter, expressing concerns with Dr. B's earlier assessment that his sister did not have capacity, and asked him to reassess her. This letter also raised questions about the care given and influence allegedly wielded by the patient's step-daughter, as well as concerns about the patient's well-being.

Dr. B told the College that until he received that letter, he had been unaware of any conflict regarding management of the patient's affairs and had witnessed only concern and interest on the part of the step-daughter.

In early May 2002, the patient was assessed by the Capacity Assessment Office and found to be competent. The assessor's report stated that the patient answered questions in a lucid, clear manner and that she had no difficulty recalling dates or time and was at all times fully aware of everything that was being said to her.

Shortly thereafter, the document identifying the step-daughter was revoked.

In its decision, the Complaints Committee stated that the opinion provided by Dr. B was unreasonable in the circumstances. While Dr. B did have some information available to him from other sources, including a neurology consult from 1998, CCAS notes, and the observations of the patient's step-daughter who visited her on a regular basis, as well as his own brief observation of the patient after her husband's death, the Committee is of the view that this was not sufficient evidence to allow him to declare a finding of incapacity. It is improper and unreasonable for a physician to rely almost exclusively on third party information in making a determination regarding capacity. There are certain general protocols that are followed in making this type of assessment, and it would appear to the Committee that Dr. B failed to follow these protocols.

While it is clear to the Committee that Dr. B was motivated by the patient's best interests in this case, the potential effects of his failure to arrange for a proper capacity assessment, either by himself or a qualified capacity assessor, prior to making his recommendations that Powers of Attorney be exercised, were significant for the patient, both financially and emotionally.

The Committee counselled Dr. B to ensure that any opinion regarding capacity, made for the purpose of activating a Power of Attorney, is made in accordance with the procedures set out in the *Substitute Decisions Act*, and in accordance with any guidelines established by the Ministry of the Attorney General.



## CAPACITY CONCERNS – CASE 2

The issue of whether a physician exceeded her authority was at the heart of another case seen by the College's Complaints Committee.

The patient was an 80-year-old widower living alone in a small community until he was admitted to hospital, after being found on the floor of his home in a state of incoherence, incontinence, unable to get up, with mild delirium, and dehydrated.

When Dr. C examined the patient he was unable to provide any recent history of his illness, but he was aware his wife had recently passed away and he stated that he was no longer able to care for himself.

Based on her examination, Dr. C formed the opinion that the patient was unable to make decisions on his own behalf. She requested instructions regarding his care from the person – Ms. M – identified in the patient's Power of Attorney (POA).

Dr. C – as the most responsible physician in this patient's care – consulted with Ms. M regarding the patient's treatment for prostate cancer and dehydration. Several weeks after the patient was admitted, the patient's brother attended at the hospital to have his brother's POA for personal care and property revoked. The patient signed the document, but the doctor did not accept the revocation, on the basis that the patient was not competent to sign it.

The brother then made attempts to confirm that the patient was legally competent. He arranged for a Designated Capacity Assessor to assess the patient. The request to conduct the capacity assessment was denied.

The patient's brother complained to the College that the doctor had behaved unprofessionally and exceeded her authority as a physician when she refused to accept the revocation of the continuing Powers of Attorney for property and personal care and for failing to permit a capacity assessment to be conducted by a Designated Capacity Assessor.

After a careful study of all the materials gathered in the course of this investigation, the Complaints Committee decided that the doctor handled this matter wisely and appropriately in relation to the general legal issues involved and with sensitivity in terms of what she learned about the patient and his circumstances.

There is ample documentation that the patient was not competent during the course of his stay in hospital. Importantly, this was an opinion held not only by the most responsible physician, but also by other medical professionals who were properly consulted by the doctor on this very issue.

In light of the shared opinion of three different medical professionals that the patient was incompetent, the Complaints Committee stated that it was entirely reasonable of the most responsible physician to refuse to accept the revocation document that the brother executed.

The Complaints Committee also held the view that the physician responded appropriately when a Designated Capacity Assessor attended to see the patient at the request of his brother. Given that the original POA was not available at the time to provide consent for this assessment (a consent that would have been unlikely anyway, based on the information supplied by the original POA to the College), the doctor properly consulted with the hospital administration. After the administration apparently consulted the hospital legal department, she then followed their advice and refused to allow the assessor's visit. In a situation such as this, it is entirely reasonable for a physician to take the advice offered to him/her by senior hospital administrators and legal counsel.

The Complaints Committee decided to take no further action on this matter.

and the person's response to the finding of incapacity should be documented in the person's chart. The charting of a finding of incapacity is essential for clinicians either to defend the decisions and to evidence that the finding was made at a particular time.

Identify the Substitute Decision Maker (SDM) and provide all the information required to make the decision. If the person does not contest the finding of incapacity or request another SDM, treat the person, in accordance with the decision made by the SDM.

### Is the person contesting the finding of incapacity or requesting another substitute decision maker/representative?

The person should proceed to make an application to the Consent and Capacity Board. The physician advises the person on how to proceed. Do not initiate any non-emergency treatment until the Consent and Capacity Board has rendered a decision, or 48 hours have elapsed and no formal application to the Board has been made. It is rare for a person suffering from dementia to contest the finding of incapacity. It is even less common for the person to contest the decision of the Board. (For further information, consult [www.ccboard.on.ca](http://www.ccboard.on.ca)).

### What is the Consent and Capacity Board?

The Consent and Capacity Board is an independent quasi-judicial tribunal created by the provincial government. It conducts hearings under the *Health Care Consent Act*, the *Mental Health Act*, and *Substitute Decisions Act*. Board members are lawyers, psychiatrists, and members of the general public.

## Who may act as a SDM?

The physician must obtain consent from the highest ranked eligible person identified in the hierarchy listed in Section 20(1) of the *Health Care Consent Act*.

1. Guardian of the person (under the *Substitute Decision Act*).
2. Attorney for Personal Care
3. Representative appointed by the Consent and Capacity Board
4. Spouse/partner
5. Child/parent
6. Parent with right of access
7. Sibling
8. Any other relative (related by blood, marriage or adoption)

The SDM must be capable with respect to the treatment, be at least 16 years of age, be available and be willing to assume the responsibility of giving or refusing consent and not be prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on behalf of the incapable person. Health practitioners are permitted to rely on assertions from persons that they are the substitute decision maker.

If there is no guardian, attorney or board appointed representative in existence, the health practitioner should contact, in descending order of priority the categories of people noted above. In this instance, it is possible for a person who is lower ranked to make the decision if he or she is present or has been contacted and asserts that a higher ranked person would not object to him or her making the decision. If no one is available, a treatment consultant from Public Guardian and Trustee (PGT) must make the decision.

## How does a SDM make decisions for an incapable person?

The SDM who is giving or refusing consent is expected to make decisions based on the incapable person's known wishes, which the incapable person expressed when he or she was 16 or more years of age and capable. If such wishes are not known or are impossible to comply with, the SDM makes the decision in the incapable person's best interest.

## When and how does one involve the Public Guardian and Trustee (PGT)?

If there is no SDM, health practitioners should contact the office of the PGT and speak to a treatment decision consultant. Provide information regarding the proposed treatment to the consultant. If the treatment is medication, the consultant will request the name of the medication and dosage. You must obtain approval to use PRN medications. The PGT will want to confirm that no other SDM is available if the person is unknown to them. The consultant will usually give a decision regarding treatment within a few hours to a few days. Until you obtain consent, you may use "emergency treatment" if the situation constitutes an emergency. The website is: [www.attorneygeneral.jus.gov.on.ca/english/family/pgt/](http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/).

## How does one arrange for a second opinion regarding capacity to consent to a specific treatment in a person with dementia?

For an inpatient in hospital, request a consultation from the psychiatric service if available, or from another health practitioner.

For a patient in the community or



in a nursing home, you may be able to refer to an outreach geriatric psychiatry service.

## What does a health practitioner do if he or she believes the SDM is not acting in the best interests of the incapable person?

The health practitioner can review the situation with the SDM and ensure that he or she has all the relevant information. If the practitioner continues to believe the SDM is not respecting the person's prior wishes or acting in the best interest of the incapable person, he or she can request a hearing with the Consent and Capacity Board which is authorized to override the decision.

## What happens if two equally ranked SDMs disagree?

The health practitioner may try and resolve the disagreement, but if this is unsuccessful, he or she may contact the Public Guardian and Trustee. Alternatively, one or more of the equally ranked SDMs may apply to the Consent and Capacity Board to be appointed as representative and thus acquire the sole right to make the decision.

## What do you do if you judge that the SDM is incapable of making a treatment decision?

The legislation states that the SDM must be capable. This is important ►►

because someone with dementia may have an SDM who becomes incapable from a dementing illness or other reason. It is advisable to document the reason for your finding that the SDM is incapable and inform the SDM of your opinion in writing and suggest that the person undergo an independent assessment. The next ranked person then becomes the SDM.

### What if hospitalization is required for the treatment?


A SDM who consents to a treatment on an incapable person's behalf may consent to the incapable person's admission to a hospital or psychiatric facility for the purpose of the treatment. If the incapable person objects to being admitted to a psychiatric facility the *Mental Health Act* needs to be followed.

## Conclusion

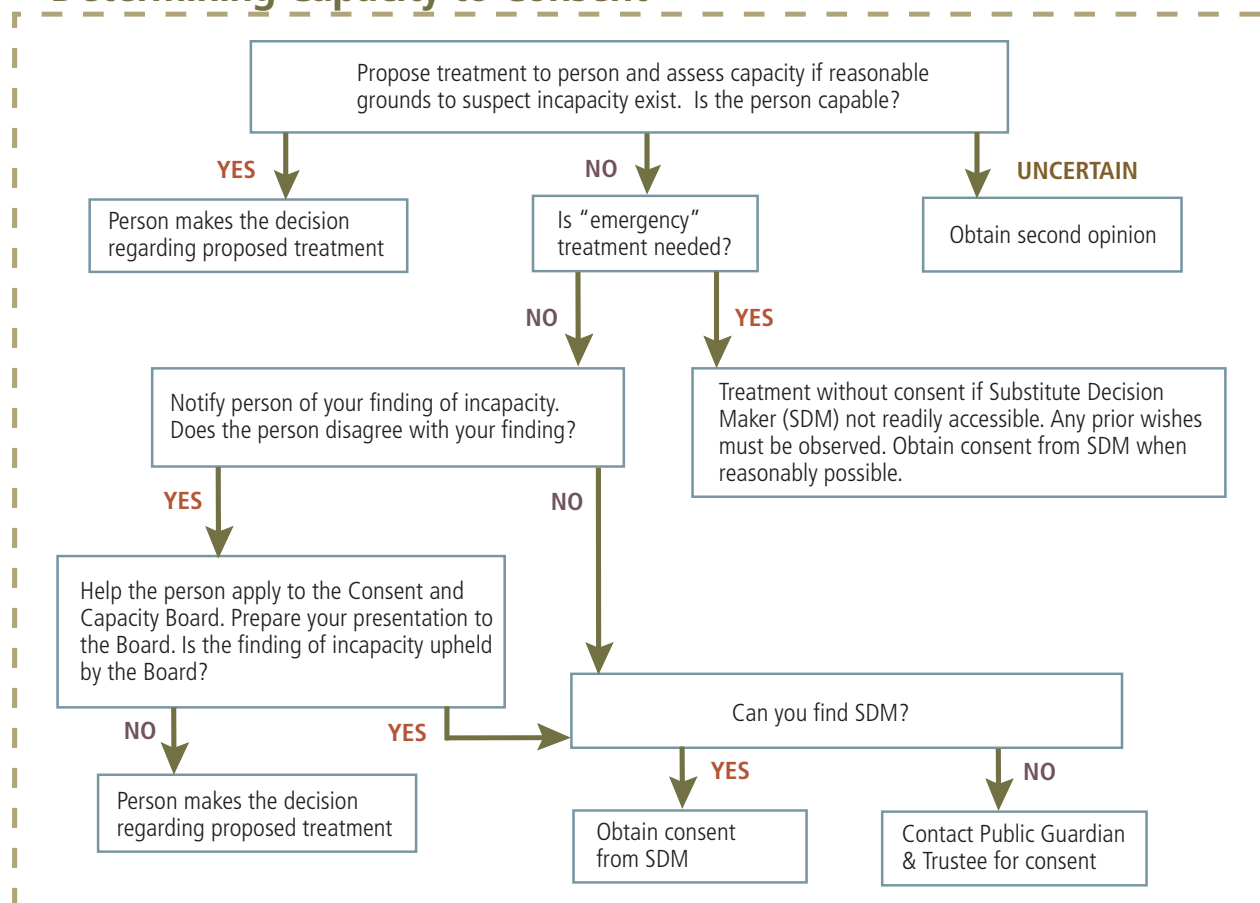
Assessing capacity and obtaining appropriate consent is very important. Following the above guidelines should aid the physician dealing in assessing capacity and in obtaining lawful consent in most circumstances. If there

is any doubt, it is advisable to call the Physician Advisory Service of the CPSO or the Canadian Medical Protective Association for further guidance.

## Resources:

- **College of Physicians and Surgeons of Ontario**  
Physician Advisory Service,  
Phone: (416) 967-2600 x606  
[www.cpsso.on.ca](http://www.cpsso.on.ca)
- **Canadian Medical Protective Association**  
**Office of the Public Guardian and Trustee**  
Phone: (613) 241-1202 or  
1-800-891-0506 (Monday to Friday 8am-6pm)  
1-800-387-2127 (Saturday/Sunday/holidays 8am-6pm)  
[www.attorneygeneral.jus.gov.on.ca/english/family/pgt/](http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/)
- **Ontario Legislation**  
[www.e-laws.gov.on.ca](http://www.e-laws.gov.on.ca)
- **Consent and Capacity Board**  
[www.ccboard.on.ca](http://www.ccboard.on.ca)  
Phone: (416) 924-4961 or 1-800-461-2036 

## Determining Capacity to Consent



Reprinted with permission from the Mini Task Force of Capacity Issues, The Dementia Network of Ottawa