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Practice Standard on Consent to Treatment (Updated: December 01, 2022)

Practice Standards of the College of Traditional Chinese Medicine Practitioners & Acupuncturists of British Columbia (the "College") set out minimum requirements for the professional conduct of TCM professionals practising in British Columbia. Together with the *Jurisprudence Handbook* and relevant legislation and case law, they will be used by the College and its Committees when considering practitioner practice or conduct.

Within the Practice Standard, the term 'must' is used to indicate a College requirement and the term 'advised' is used to indicate that the practitioner can use reasonable discretion when applying this expectation to practice.

Definitions

Consent to treatment: The voluntary agreement of a patient or substitute decision-maker to a specific proposed assessment, treatment, or procedure which can be withdrawn at any time.

Implied consent: Consent communicated through non-verbal actions.

Capacity: A person has the ability to understand the information that is relevant to making a decision about the proposed assessment, treatment or procedure and can appreciate the reasonably foreseeable consequences of a decision or lack of decision of accepting or refusing the proposed assessment, treatment, or procedure. Capacity to consent to a treatment can change over time. The capacity varies according to the individual patient and the complexity of the specific treatment decision.

Minor: A person under the age of 19.

Mature Minor Consent: This is the consent that a minor gives to receive or refuse a proposed assessment, treatment or procedure after a practitioner determines they understand the nature, consequences and reasonably foreseeable benefits and risks of the proposed assessment, treatment, or procedure.

Substitute decision-maker: A person authorized to give or refuse consent to treatment on behalf of a patient who lacks capacity.

Standard

The practitioner **must** practice in accordance with the following requirements:

General Principles

1. The practitioner is aware of, and is in compliance with, all of the requirements in the *Health Care (Consent) and Care Facility (Admission) Act (HCCCFAA)* and the *Infants Act.*
2. Consent to health care can be given or refused in three ways: written, verbal, or implied.
3. The practitioner obtains a valid consent before a proposed assessment, treatment, or procedure is provided. That consent is specific and cannot be assumed based on previous consents given or generic consents that are not specific to the proposed intervention.
4. The patient has the right to refuse or withdraw consent to treatment at any time, and the practitioner respects the patient's decision to choose what to consent to and what to refuse.
5. As part of ongoing communication with a patient, the practitioner checks with the patient to reconfirm consent when there are any signs that the patient's understanding of or wish to receive an assessment, treatment, or procedure has changed. The practitioner adjusts the communication approach for each patient to ensure that the information and explanations are clearly understood by the patient.[1]

Determining Capacity to Give Consent

6. When obtaining consent for treatment, the practitioner ensures that the patient is capable of giving consent. The practitioner is entitled to presume capacity unless there are reasonable grounds to believe the patient lacks capacity to consent to treatment (e.g., something in a patient's history or behaviour raises questions about their capacity to consent to treatment).
7. The first step in determining the test for capacity is to consider whether the patient is able to understand the information that is relevant to making a decision about the proposed intervention. The patient needs to be capable of intellectually processing the information as it applies to them, including the potential benefits and risks. The second step in determining capacity is whether the patient is able to appreciate the reasonably foreseeable consequences of a decision or lack of decision to accept or refuse the proposed intervention.
8. The practitioner considers the patient's capacity at various points in time and in relation to the specific assessment, treatment, or procedure being proposed.

Incapable Patients and Substitute Decision-Making

9. Where there are reasonable grounds to conclude that a patient is incapable of giving informed consent to treatment, the practitioner, where possible, informs the patient who lacks capacity that a substitute decision-maker will assist them in understanding the proposed assessment, treatment, or procedure and that the substitute decision-maker will be responsible for the final decision. When appropriate, the practitioner needs to involve the patient who lacks capacity to the fullest extent possible, in discussions with the substitute decision-maker. A substitute decision-maker is chosen according to the priority and qualification specified in section 16 of the *Health Care (Consent) and Care Facility (Admission) Act*.

[1] According section 8 to *Health Care (Consent) and Care Facility (Admission) Act (HCCCFAA),* the practitioner has a duty to communicate in a manner appropriate to the patient's skills and abilities.

10. The practitioner documents the substitute decision-maker's name and contact information in the patient's clinical file.

Minors

11. If a minor is capable of giving consent to treatment, the practitioner accepts that consent directly without obtaining consent from the minor's parent or guardian.

12. The test for capacity to consent to a treatment is not age-dependent and, as such, the practitioner makes a determination of capacity for a minor just as the practitioner would for an adult when accepting a mature minor consent.

13. The practitioner obtains consent from a parent or guardian if the minor does not have capacity to provide consent to treatment.

Obtaining and Documenting Consent

14. For consent to treatment to be valid, the practitioner ensures that:

    a. The consent is directly obtained from the patient or from the patient's substitute decision-maker, if the patient lacks capacity to consent to treatment.

    b. The consent is informed and includes the following elements:[2]

        - Nature of the proposed assessment, treatment, or procedure
        - Who will be performing the proposed assessment, treatment, or procedure
        - Rationale for the proposed assessment, treatment, or procedure
        - Potential risks and benefits of the proposed assessment, treatment, or procedure
        - Alternatives to the proposed assessment, treatment, or procedure
        - Notification to patient of their right to refuse or withdraw consent at any time
        - Consequences of not having the proposed assessment, treatment, or procedure
        - Notification to patient of their right to ask questions and receive answers about the proposed assessment, treatment, or procedure.

    c. The consent is given voluntarily, without coercion, fraud, or misrepresentation.

    d. The consent relates to the specific assessment, treatment, or procedure being proposed.

    e. The practitioner discusses consent with the patient or the substitute decision-maker (as the case may be) when providing the information specified in section 14(b), ensures the information provided is understood, and, as such, takes reasonable steps to facilitate comprehension of the information provided.

15. The practitioner documents the receipt, refusal, or withdrawal of consent for treatment in the clinical record.

[2] Adapted from the *Jurisprudence Handbook (page 11)* and Section 6 of the *HCCCFAA.*

16. For follow-up treatments or procedures with no change to the initial treatment plan, the practitioner will ensure that the patient's previous consent is still valid. If there is a change to the treatment plan (for example, a new procedure is introduced) that is not covered by the previous consent, the practitioner needs to obtain consent for the change to the specific course of treatment or procedure.[3]
17. The practitioner documents any concerns raised during the consent process and actions taken to address them (e.g., a patient is determined to be incapable of providing consent and an authorized substitute decision-maker is identified) in the clinical record.
18. The practitioner documents the rationale and decision when a mature minor consent is accepted in the clinical record.

Practice Advice

It is advised that the practitioner communicate in a manner appropriate to the patient's culture, language, and personal preferences. For example, the practitioner can use plain language, age-appropriate terminology, and qualified interpreters (if appropriate) to ensure the patient has an adequate understanding in order to make their own decision to give or withdraw informed consent to treatment.

The practitioner is advised to consider and address language and/or communication issues that may impede a patient's ability to give valid consent and to obtain independent legal advice if they are unsure of their legal obligations in relation to consent to treatment.

The use of written consent forms is encouraged. If a written consent form is used, the patient's name, signature, and date of signature should be included in the record, in addition to the elements of informed consent outlined in section 14(b).

Some professional liability insurance providers may require the practitioner to include specific provisions in the consent form outlining specific health risks to a patient in advance of providing the treatment and may decline to indemnify the practitioner in the absence of such provisions. One such example for acupuncture is mentioning the risk of pneumothorax. The practitioner is advised to review the terms of the practitioner's professional liability insurance policy.

Adapted from and thanks to:

College of Physicians and Surgeons of BC

https://www.cpsbc.ca/files/pdf/NHMSFAP-AS-Consent.pdf

College of Physicians and Surgeons of Ontario

[3] According to Section 9.2 of the *HCCFAA*, consent to health care applies only to the specific health care that a patient has consented to.

https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Consent-to-Treatment

British Columbia Ministry of Health

https://www.health.gov.bc.ca/library/publications/year/2011/health-care-providers'-guide-to-consent-to-health-care.pdf

Resources

College of Traditional Chinese Medicine Practitioners & Acupuncturists of British Columbia (2016). *Jurisprudence course handbook.* Available from: https://www.ctcma.bc.ca/media/1063/jurisprudence-handbook-en-web.pdf

College of Traditional Chinese Medicine Practitioners & Acupuncturists of British Columbia (2016). *Clinical Record Keeping Sample Form.* Available from: https://www.ctcma.bc.ca/media/1639/clinical-record-keeping-practice-standard-sample-forms.docx

Government of British Columbia. *Health Care (Consent) and Care Facility (Admission) Act*, [RSBC 1996], Chapter 181. Available from: https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96181_01

Government of British Columbia. *Infants Act*, [RSBC 1996], Chapter 223. Available from: https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96223_01.