

The Canadian Law of Consent to Treatment.

By LORNE E. and FAYE A. ROZOVSKY.

Toronto and Vancouver: Butterworths Canada Ltd. 1990. Pp. 151. (\$43.95)

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A 15 year-old high school student presents herself at the outpatient family planning clinic requesting a prescription for birth control pills. . . .¹

An elderly gentleman is disoriented as to time and place. On some days he is quite lucid and coherent. On other occasions, the man is irrational, incoherent and terribly withdrawn. Medical management has failed to correct the gangrenous condition in his left foot and the doctors have determined that it should be amputated to save his life. . . .²

These are two of the many examples cited by the authors to demonstrate the complexities which arise in obtaining the requisite consent to treatment.

This concise and well-written text begins with the premise that consent is a "process" whereby the care-giver and the recipient of care enter into a special contractual relationship. "The process . . . involves far more than acquiring a signature on a consent form. It requires effective communication skills and an ongoing working relationship of trust between the care-giver and the recipient of treatment."³

The authors establish a set of criteria to obtain valid consent, each aspect of which must be observed:⁴

1. The patient must be legally competent to consent to treatment.
2. The patient must possess the mental capacity to authorize care.
3. The patient must receive a proper disclosure of information from the care-giver.
4. The authorization should be specific to the procedure to be performed.
5. The patient should have an opportunity to ask questions and to receive understandable answers.
6. The authorization obtained should be free of undue influence and coercion.
7. The authorization obtained should be free of misrepresentation of material information.

Each of these criteria is explored in detail and explained by example.

As nice as any listing of criteria is, reality often has a nasty habit of presenting itself in non conforming situations. The second chapter deals with the question of lack of consent in exceptional circumstances, the most

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¹ P. 126.

² P. 6.

³ P. 2.

⁴ Pp. 2-3.

common being the "medicolegal emergency", defined as "a life- or health-threatening situation requiring immediate treatment. For one reason or another, the patient cannot take part in the consent process. Moreover the situation is so urgent that there is no time to seek an authorization for care from any one else".⁵ This is distinguished from a strictly "medical emergency", where even though treatment is urgent consent might or should be obtained. Consensual issues as they apply to therapeutic privilege, prisoners, blood samples, sexual attack victims, and medication prior to treatment are also reviewed.

The next chapter examines the topic of consent and reproduction, particularly areas such as sterilization, abortion and other practical concerns including contraceptives, genetic screening, AIDS and reproduction.

Chapter 4 deals with the important area of the consent of the mentally disabled. The authors caution:⁶

There is a preconceived idea, even among those who work with the mentally disabled, that anyone who is mentally ill, mentally disabled or mentally retarded is incapable of making decisions relating to care and treatment. The care and treatment may be for the mental condition or physical well-being. Such a preconception does not conform with reality.

In fact, some patients suffering from mental illness, disability, or retardation may be capable of consenting to treatment, whereas others may not. A general rule cannot be established, neither in fact or law.

They conclude:⁷

A person's ability to consent depends on the following factors:

1. The ability to understand that he has the right to either consent to or refuse treatment.
2. The ability to understand the information given to him and upon which his decision will be based, including the nature, risks, and benefits of treatment, and any reasonable alternatives to the proposed treatment along with the nature, risks, and benefits of those alternatives.

This area is directly affected by legislation particularly as it applies to hospitalized patients. The chapter specifically reviews the Nova Scotia Hospitals Act⁸ and other provincial mental health legislation, and the distinctions between voluntary and involuntary patients, hospitalization under the Criminal Code⁹ and the impact of the Canadian Charter of Rights and Freedoms.¹⁰

Consent to treatment of children also raises similar issues and the law is well canvassed both in terms of the common law ("... there exists no universal age at which patients can consent to their own medical treatment

⁵ Pp. 19-20.

⁶ P. 39.

⁷ P. 46.

⁸ R.S.N.S. 1989, c. 208.

⁹ R.S.C. 1985, c. C-46.

¹⁰ Constitution Act, 1982, Part I.

and below which they cannot authorize care. Whether a child can consent or not depends on the child in question, his or her mental ability and the treatment or procedure which the child is asked to understand...¹¹⁾ and the different provincial legislative schemes. The authors provide a particularly useful discussion of parental refusal of treatment and the impact of child welfare legislation, followed by a brief consideration of parent-child disagreements, disagreements between parents and children in temporary custody.

Human research and tissue donation, another controversial field where consent is problematic, is addressed in Chapter 5. Human research is not governed under any federal legislation; rather it is conducted under a set of guidelines authorized by the Medical Research Council. The text reviews these guidelines and such topics as deception and the use of placebo, cross-cultural research, and children and incompetent persons as research subjects. An examination of Human Tissue Gift Acts, inter vivos organ donations and cadaver organ donations completes the chapter.

In Chapter 7 the authors suggest that a patient not only has a right to consent to treatment but also the right to refuse treatment. "In many situations, decisions to refuse care have generated ill-will between doctors and patients."¹² Objection to treatment on religious grounds both for children and adults is reviewed, and there is an equally interesting discussion of refusal of life prolonging treatment. First, a distinction is drawn between life-saving care and life-sustaining care:¹³

"Life-saving" treatment refers to medical and surgical interventions that are necessary to prevent death from life threatening illnesses or injuries.

"Life-sustaining" treatment is of a different character:¹⁴

Typically this category encompasses patients with a terminal prognosis or a life filled with rather serious chronic illness... medical or surgical care will not "cure" the underlying problem experienced by the patient. Rather, the "treatment" will only serve to sustain life.

For many in society, a decision to provide life-saving therapy is quite acceptable. In part, this reflects both the social and legal inclination to err on the side of life.

However, the same is not true of life sustaining measures. Many people take a dim view of the personal and financial costs associated with seemingly endless interventions designed to prolong life when there is no hope of recovery. Indeed this is reflected in the growing clamour to allow such patients to die "in dignity" rather than lingering on under advances attributed to biomedical technology.

The authors then consider The Canadian Charter of Rights and Freedoms. They see the Charter as having important implications, particularly as it applies to the right to refuse treatment. Section 7 (right to life, liberty and security of the person), 12 (cruel and unusual punishment),

¹¹ Pp. 54-55.

¹² P. 87.

¹³ P. 91.

¹⁴ Pp. 91-92.

and 15(1) (equal benefit of the law without discrimination . . . based on . . . religion, sex, age, or mental or physical disability) are all capable of affecting decisions in respect of refusing treatment.

The voluntary assignment of the patient's consent to a substitute decision-maker when the patient is incapacitated ("the durable power of attorney") is also discussed in this chapter. In Nova Scotia, the Medical Consent Act¹⁵ is one attempt to legislate in the field of durable powers of attorney and although the authors find some shortcomings with this Act they concede "the Nova Scotia law is a positive step in the right direction".¹⁶ The living will or "natural death acts" which direct the ruling out of "*heroic or extraordinary treatment*"¹⁷ are generally not recognized in Canadian law. As the authors comment: "In the absence of enabling legislation, it is clear that the current living wills in use in Canada are without legal punch. At best, care-givers may respect the directives and carry out the patient's wishes. At worst, the documents may be ignored."¹⁸ "Do not resuscitate" (DNR) orders and "do not hospitalize" (DNH) orders are reviewed and useful guidelines are provided in each instance to help care-givers establish policies in these areas.

The book broadens its focus in the following chapter, "Documenting Consent". Even though the authors insist that consent is a "process" incongruous with standard forms, they also feel that forms and documentation have a valid, indeed vital place in the process. In addition to commenting on the traditional consent form and the impact of provincial statutes, they explore documentation for special circumstances: leaving hospital against medical advice, telegraphic and telephone consents, video-taped consents and refusing medical care. The Appendix contains several useful precedents which complement this chapter, including the right way and the wrong way to write a consent note in the patient record, common clauses used in patient consent forms, sample consent form for leaving hospital against medical advice, consent to treatment for a child form and (interestingly) a sample living will.

Chapter 9 deals with the area of consent litigation. It follows the development of case law in Canada where prior to 1980 most cases involving lack of consent were brought as actions in battery. As a result of the

¹⁵ R.S.N.S. 1989, c. 279.

¹⁶ P. 98.

¹⁷ P. 96.

¹⁸ *Ibid.*

Supreme Court of Canada decision in *Reibl v. Hughes*¹⁹ and *Hopp v. Lepp*²⁰ most are now brought as actions in negligence.²¹

These two decisions had the following effect on consent litigation in Canada.

A specific guideline was established regarding what a doctor must tell a patient. Rather than the uncertain standard of what is reasonable, the court stated in the *Hopp v. Lepp* case, that a patient had the right to be informed of all the material risks. The material risks were those which carried a risk of serious injury or death.

The Rozovskys have produced a practical guide for many involved in health care. It is not a scholar's tome, peppered with citations and lengthy discussions of various judicial attitudes to the issues. Rather this book is reminiscent of many other of the Rozovsky texts such as *Canadian Hospital Law: A Practical Guide*²² in that it is skilfully written and comprehensible to the lay reader. It should not be considered the definitive text on the law of consent and other texts should be consulted to round out the legal implications of the various issues raised, such as Ellen Picard's text, *Legal Liability of Doctors and Hospitals in Canada*.²³

This book is clearly a valuable tool for the lawyer, nurse, doctor, administrator or hospital board member looking for an intelligible reference to guide him or her through the mine field that consent presents.

¹⁹ [1980] 2 S.C.R. 880.

²⁰ [1980] 2 S.C.R. 192.

²¹ P. 119.

²² (2nd ed., 1979).

²³ (2nd ed., 1984).