Consent: A Guide for Canadian Physicians
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Preface to First Edition

Consent to medical treatment has probably never been a particularly easy matter either for physicians or for patients. The physician needs to be fair and frank in informing the patient about the proposed care, while at the same time having valid concern for the wellbeing of the patient and being appropriately forthright in recommending the management which medically is indicated. The patient resents the feeling that the physician may be taking control, but at the same time recognizes that the physician is better qualified to judge what course of care is likely best. Precisely because consent is of such basic importance and yet can be difficult for those directly involved, society has set out its requirements and expectations in the form of statutes and court decisions.

It was in 1972 that the Canadian Medical Protective Association published jointly with the Ontario Hospital Association a booklet entitled “Consents: A Guide to Hospitals and Physicians in Ontario”. The author was Dr T.L. Fisher, then Secretary-Treasurer of the Canadian Medical Protective Association, and a person eminently qualified to set down, for the first time, information and suggestions intended as a guide to physicians and hospitals.

In 1983 the CMPA collaborated again with the Ontario Hospital Association in publishing an updated booklet, that one entitled “Consent: What Every Hospital and Physician in Ontario Should Know”. It was co-authored by Dr F. Norman Brown who had succeeded Dr Fisher as Secretary-Treasurer of the Canadian Medical Protective Association, and by Mr Kenneth G. Evans of General Counsel to the Association. That booklet reflected a number of changes, chief among which was the more stringent standard of disclosure which had been imposed by the Supreme Court of Canada in 1980.

Just as society’s expectations and requirements in matters of consent change, so also is there gradual change in the nature of the relationship between physicians and patients and in the variety of contexts in which medical care is given. It is timely, therefore, that there should now be a thorough review of the highlights of consent as it pertains to medical management. The Canadian Medical Protective Association is indeed grateful that this task was taken up by Dr Brown, now Consultant to Council of the CMPA and by Mr Evans, now its senior legal adviser, and the Association is proud to present to the Canadian medical profession “Consent: A Guide for Canadian Physicians”. It is an honour for me to commend this new booklet to you.

Stuart B. Lee, MD, FRCSC
February 1990
Secretary-Treasurer
Preface to Third Edition

The Canadian Medical Protective Association is pleased to present the third edition of its booklet entitled Consent: A Guide for Canadian Physicians. This edition is marked by several useful and important improvements over the first edition which was published in 1990.

At a number of places the text has been rearranged and reordered. Throughout there has been a change in style.

Several sections, most obviously Age of Consent and Mental Incapacity, have been reworked and updated by reference to recent legislation.

The section entitled Treatment in Canada of U.S. and Other Foreign Residents is completely new. It is based in large part upon an item which first appeared in the CMPA’s Information Letter, Spring 1995, Volume 10, No. 2.

It is the Association’s hope that physicians will find this concise and readable booklet helpful in their understanding of consent matters and in their professional relationships with patients.

July 1996

Stuart B. Lee, MD, FRCSC
Secretary-Treasurer
Introduction

In the shorter Oxford dictionary, consent is defined as “the voluntary agreement to or acquiescence in what another person proposes or desires; agreement as to a course of action”.

In the medical context and as the law on consent to medical treatment has evolved, it has become a basic accepted principle that “every human being of adult years and of sound mind has the right to determine what shall be done with his or her own body”. Clearly doctors may do nothing to or for a patient without valid consent. This principle is applicable not only to surgical operations but also to all forms of medical treatment and to diagnostic procedures that involve intentional interference with the person.

That consent to treatment was lacking or inadequate continues to be a frequent claim against physicians. Obviously it is important therefore that doctors be aware of their legal obligations in obtaining consent from patients. It is hoped this booklet will assist in strengthening this awareness. It is not intended as a legal treatise on the subject of consent but rather as a practical guide for physicians in their day to day dealings with patients.
Types of Consent

Consent to treatment may be implied or it may be specifically expressed either orally or in writing.

**Implied Consent**

Much of a physician’s work is done on the basis of consent which is implied either by the words or the behaviour of the patient or by the circumstances under which treatment is given. An example can be used to illustrate. It is common for a patient to arrange an appointment with a doctor, to keep the appointment, to volunteer a history, to answer questions relating to the history and to submit without objection to physical examination. In these circumstances consent for the examination is clearly implied.

The foregoing notwithstanding, in many situations the extent to which consent was implied may later become a matter of disagreement. For this reason, physicians must be sure the actions of the patient do, in fact, unequivocally imply and would be interpreted by others to have implied permission for whatever the doctor proposed. When there is doubt it is preferable the consent be expressed.

**Expressed Consent**

Expressed consent may be in oral or written form. It should be obtained when the treatment is likely to be more than mildly painful, when it carries appreciable risk, or when it will result in ablation of a bodily function.

Although orally expressed consent may be acceptable in many circumstances, frequently there is need for written confirmation. As physicians have often observed, patients can change their minds or may not recall what they authorized; after the procedure or treatment has been carried out, they may attempt to take the position it had not been agreed to or was not acceptable or justified. Consent may be confirmed and validated adequately by means of a suitable contemporaneous notation by the treating physician in the patient’s record.

Expressed consent in written form should be obtained for surgical operations and invasive investigative procedures. It is prudent to obtain written consent also whenever analgesic, narcotic or anaesthetic agents will significantly affect the patient’s level of consciousness during the treatment.
Emergency Treatment

To the general rule that consent must always be obtained before any treatment is administered, there is an important exception. In cases of emergency when the patient is unable to consent and a substitute decision-maker is not readily available, a doctor has the duty to do what is immediately necessary without consent. For the doctor to declare any clinical situation an emergency for which consent is not required, there must be demonstrable imminent threat to the life or health of the patient. It cannot be a question of preference or convenience; there must be undoubted necessity to proceed at the time. Further, under emergency situations, treatments should be limited to those necessary to deal with imminent threats to life, limb or health. As soon as the patient is able to make decisions and regains the ability to give consent, a proper and “informed” consent must then be obtained from the patient for additional treatment.

When an emergency dictates the need to proceed without valid consent from the patient, a contemporaneous record should be made explaining the circumstances which forced the doctor’s hand. If the circumstances are such that the urgency might be questioned at a later date, arranging a second medical opinion would be prudent if it is possible to do so.
Although most legal actions against doctors are based in negligence on the grounds that the consent process was in some respect inadequate or incomplete, assault and battery may be alleged in certain specific circumstances. A physician may be liable in assault when no consent was given at all or when the treatment went beyond or deviated significantly from that for which the consent was given. Allegations of assault and battery might also be made if consent to treatment was obtained through serious or fraudulent misrepresentation in what was explained to the patient.

Thus, as has happened in various legal actions, it was seen as an assault to carry out an amputation without having received consent to do so; to administer an intravenous anaesthetic agent into the left arm when the patient had specifically forbidden it; to sterilize a patient when consent had been given for a Caesarean section only; to operate on the patient’s back when consent had been given only for a procedure on the toe.

In each of these examples, the doctors knew they were proceeding in the medical best interests of the patients and took measures which were clearly medically indicated. However, our courts have repeatedly affirmed that good intentions of the doctor cannot be substituted for the will of the patient.
Requirements for Valid Consent

For consent to serve as a defence to allegations of either battery or negligence, it must meet certain requirements. The consent must have been voluntary, the patient must have had the capacity to consent and the patient must have been properly informed.

Voluntary Consent

Always patients must be free to consent to or refuse treatment, free of any suggestion of duress or coercion. Consent obtained under any suggestion of compulsion either by the actions or words of the doctor or others may be no consent at all and therefore may be successfully repudiated. In this context doctors must keep clearly in mind there may be circumstances when the initiative to consult a doctor was not the patient’s, but was rather that of a third party, a friend, an employer, or even a police officer. Under such circumstances the doctor may be well aware that the patient is only very reluctantly following the course of action suggested or insisted upon by a third person. Then, doctors should be more than usually careful to assure themselves patients are in full agreement with what has been suggested, that there has been no coercion and that the will of other persons has not been imposed on the patient.

Competence to Consent

An individual who is able to understand the nature and anticipated effect of proposed treatment and alternatives, including the consequences of no treatment, is competent to give valid consent. However, there are special circumstances to which particular attention must be given.

Age of Consent

The legal age of majority has become progressively irrelevant in recent years in determining when a young person may consent to his or her medical treatment. “Capacity” to consent or refuse treatment is now seen as an ability to understand the information that is relevant to making a decision about the proposed treatment and to appreciate the reasonably foreseeable consequences of a decision or lack of decision. As a result of consideration and recommendations by law reform groups as well as the evolution of tort law on consent, the legal concept of the “mature minor” has become widely accepted and firmly entrenched. The determinant has become the extent to which the young person’s physical, mental, and emotional development will allow for a full appreciation of the nature and consequences of the proposed treatment, including the refusal of such treatment.

Legislation in a number of provinces and the territories has codified existing tort law on consent to varying degrees. Although legislative details differ somewhat, the issue of a young person’s capacity to consent, the mature minor rule, is central to most of the statutes. Only the Province of Quebec has established a fixed age of 14 years, below which the consent of the parent or guardian or of the court is necessary for the purposes of proposed treatment. There may be times, even in the common law jurisdictions, when the prudent doctor, with the
concurrence of the patient, will wish to involve a parent or guardian in pretreatment discussions. This is especially so when the patient is under the age of 16 years or if the proposed treatment carries serious risk or might be regarded as controversial in nature.

When a parent or other substitute decision-maker is involved, a consideration of what might be seen as being in the best interest of the young person will take on greater importance when obtaining consent. This is particularly so when there is refusal of treatment which the doctor regards as medically necessary. In these circumstances there is an obligation on doctors to report the matter to child protection authorities.

**Mental Capacity**

It is well accepted that a person suffering from mental incapacity may still retain sufficient mental ability to give valid consent to medical treatment. Again, it depends on whether the patient is able to appreciate adequately the nature of the proposed treatment, its anticipated effect and the alternatives. Therefore, many individuals who are mentally infirm or who have been committed to a psychiatric facility continue to be capable of controlling and directing their own medical care, including the right to refuse treatment.

It is now possible in the majority of provinces for a patient to execute an Advance Directive as to future care in the event that the patient becomes mentally incapacitated or unable to communicate his or her wishes. An Advance Directive may contain explicit instructions relating to consent or refusal of treatment in specified circumstances, sometimes referred to as a living will. As well, an Advance Directive may be used to appoint or designate an individual who will be empowered to make substitute decisions about consent or refusal of treatment in the event that the patient becomes mentally incapacitated.

There is also in place in several provinces specific legislation which codifies the law of consent. Typically such legislation sets out and ranks a list of individuals, usually family members, who are authorized to give or refuse consent to treatment on behalf of an incapable person. These substitute decision-makers must act in compliance with any prior expressed wishes of the patient, or in the absence of any expression of will in accordance with the best interests of the patient. Substitute consent, including that of a parent for a child, cannot be utilized for proposed treatment which might be regarded as non-therapeutic, as for example, contraceptive sterilization.

In the absence of an Advance Directive or a substitute decision-maker authorized by statute, only the court or someone appointed by the court may properly consent to or refuse medical treatment on behalf of a mentally incapacitated patient. Unfortunately, the legal procedure to obtain consent approval for the appointment of a committee or guardian of the patient is often lengthy and unduly expensive. As a result, and from a practical standpoint, physicians have often proceeded simply on the basis of the approval of the family where the medical treatment is clearly required and in the best interests of the incapacitated patient. Should there be any disagreement among members of the family, however, then specific legal advice should probably be sought about that particular situation.
Disclosure of Information

For consent to treatment to be considered valid, it must be an “informed” consent. The patient must have been given an adequate explanation about the nature of the proposed investigation or treatment and its anticipated effect as well as the significant risks involved and alternatives available. The information must be such as will allow the patient to reach an informed decision.

The obligation of disclosure must always rest with the doctor who is to carry out the treatment or investigative procedure. This obligation may be delegated in appropriate circumstances (to a PGY trainee for example) but before assigning this duty to another, the treating doctor should be confident the delegate has the knowledge and experience to provide adequate explanations to the patient.

In certain special circumstances, an obligation of pre-treatment disclosure may fall to more than one physician involved in the care. For example, a radiologist carrying out an invasive diagnostic procedure would likely be seen as responsible for explaining how the test will be done and the risks attendant upon it. The physician who ordered the test might also be expected to tell the patient, in general terms, about the nature and purpose of the test and alternatives which might be employed.
Standard of Disclosure

Although obtaining a valid consent from patients has always involved explanations about the general nature of the proposed treatment and its anticipated effect, the Supreme Court of Canada, in 1980, imposed a more stringent standard of disclosure upon physicians. The adequacy of consent explanations is to be judged by the “reasonable patient” standard, what a reasonable patient in the particular patient’s position would have expected to hear before consenting.

The Supreme Court of Canada set out in general terms the scope of the doctor’s duty in informing patients before treatment as follows:

“In summary decided cases appear to indicate that in obtaining the consent of a patient for the performance upon him of a surgical operation, the surgeon, generally, should answer any specific questions posed by the patient as to the risks involved and should, without being questioned, disclose to him the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation. However, having said that, it should be added that the scope of the duty of disclosure and whether or not it has been breached are matters which must be decided in relation to the circumstances of each particular case.”

In a subsequent decision the Court extended the obligation of disclosure as follows:

“... a surgeon must also, where the circumstances require it, explain... alternative means of treatment and their risks.”

The foregoing does provide doctors with a general basis for deciding the nature and extent of the pre-treatment information which should be given to patients but it can be difficult to apply legal generalizations to specific clinical situations. Therefore, some comment about several of the points raised in these precedent-setting judgments may be helpful. Throughout these and other legal judgments which have been rendered in more recent years, there is repeated reference to the need to disclose “material” risks to patients. However, there can be some understandable uncertainty as to what in fact does constitute a “material” risk. One court has defined it as follows:

“a risk is thus material when a reasonable person in what the physician knows or should know to be the patient’s position would be likely to attach significance to the risk or cluster of risks in determining whether or not to undergo the proposed therapy.”

Thus the particular circumstances of the patient are an important determinant of materiality.

It is clear that the materiality of a risk is influenced as well both by the frequency of the possible risk and also by its seriousness should it occur. Generally speaking, the more frequent the risk, the greater the obligation to discuss it beforehand. Further, even uncommon risks of great potential seriousness should be disclosed. In this context the Supreme Court of Canada indicated that even if a risk is “a mere possibility” yet if it carries with it serious consequences such as paralysis or death, it should be regarded as material and therefore requires disclosure.
**Consent Disclosure in Research and Experimentation**

The issue of consent merits careful consideration by those doctors who may become involved in any research work in which patients or human volunteers are asked to participate.

In terms of the extent to which risks must be disclosed, there is now less distinction between “therapeutic” and “non-therapeutic” research than in earlier years when requirements for informed consent were less stringent. Nowadays for any treatment or procedure which is innovative or could be perceived as experimental, anything which may be interpreted as going beyond the need for prophylaxis, diagnosis or therapy, an element of “research” should be assumed. In such circumstances a standard of full disclosure may be applicable when obtaining consent. The concept of therapeutic privilege is inappropriate and no information about a project or clinical trial may be hidden from a patient on the ground that disclosure would result in undue worry or anxiety. As well, researchers must recognize the potential for what might later appear to have been duress or coercion. This is a particularly important consideration if the subject stands in a doctor-patient relationship with a member of the research team.

Always a fair explanation must be given about what is proposed, its risks and discomforts, what if any benefits might accrue and, if applicable, what appropriate alternative treatments or procedures might be offered. If a blind study is involved, patients must be aware they could stand to derive no benefit at all. Researchers should offer and make themselves available to answer enquiries about what is proposed and should emphasize to patients or subjects that they are free to withdraw consent and discontinue participation in the project at any time without prejudice.

It might be argued that minors or adults with mental disability do not have the capacity to consent when research or experimentation figure to any significant extent in clinical management. Physicians should exercise a great deal of caution in dealing with such situations.

**Refusal of Treatment**

Our courts have reaffirmed repeatedly a patient’s right to refuse treatment even when it is clear that treatment is necessary to preserve life or health. However, difficulty may arise if it should later be claimed the refusal had been based on inadequate information about the potential consequences of declining what had been recommended.

In the same way as valid consent to treatment must be “informed”, so it may be argued a refusal must be similarly “informed”. Doctors thus may be seen to have the same obligations of disclosure as when obtaining consent, that is disclosure of the risk to be accepted.

When patients decide against recommended treatment, particularly urgent or medically necessary treatment, discussions about their decision must be conducted with some sensitivity. While recognizing an individual’s right to refuse, doctors must at the same time explain the consequences of the refusal without creating a perception of coercion in seeking consent. Refusal of the recommended treatment does not necessarily constitute refusal for all treatments. Reasonable alternatives should be explained and offered to the patient.

As when documenting consent discussion, notes should be made about a patient’s refusal to accept recommended treatment. Such notes will have evidentiary value if there is any controversy later about why treatment was not given.
Some Practical Considerations

The law on consent will continue to evolve, perhaps with changing emphasis on various relevant issues. However, current interpretation of legal judgments dealing with “informed consent” will allow some suggestions which may be of practical assistance to doctors in their attempt to meet the legal standards which may be imposed on them in Canada:

1. Insofar as may be possible, tell the patient the diagnosis. If there is some uncertainty about diagnosis mention this uncertainty, the reason for it and what is being considered.

2. The doctor should disclose to the patient the nature of the proposed treatment, its gravity, any material risks and any special risks relating to the specific treatment in question. Even if a risk is a mere possibility which ordinarily might not be disclosed, if its occurrence carries serious consequences, as for example paralysis or death, it must be regarded as a material risk requiring disclosure.

3. A doctor must answer any specific questions posed by the patient as to the risks involved in the proposed treatment. Always the patient must be given the opportunity to ask questions.

4. The patient should be told about the consequences of leaving the ailment untreated. Although there should be no appearance of coercion by unduly frightening patients who refuse treatment, our courts now recognize there is a positive obligation to inform patients about the potential consequences of their refusal.

5. The patient should be told about available alternative forms of treatment and their risks. There is no obligation to discuss what might be clearly regarded as unconventional therapy but patients should know there are other accepted alternatives and why the recommended therapy has been chosen.

6. Doctors must be alert to a patient’s individual concerns about the proposed treatment and deal with them. It must be remembered that any particular patient’s special circumstances might require disclosure of potential although uncommon hazards of the treatment when ordinarily these might not be seen as material. Courts have made it clear that the duty of disclosure extends to what the doctor knows or should know the particular patient deems relevant to a decision whether to undergo treatment.

7. Although any particular patient may waive aside all explanations, may have no questions, and may be prepared to submit to the treatment whatever the risks may be without any explanatory discussion, doctors must exercise cautious discretion in accepting such waivers.

8. When, because of emotional factors, the patient may be unable to cope with pretreatment explanations, the doctor may be justified in withholding or generalizing information which otherwise would be required to be given. This so-called “therapeutic privilege” should be exercised with great discretion and only when there are compelling reasons dictated by clinical circumstances.

9. In obtaining consent for cosmetic surgical procedures or for any type of medical or surgical work which might be regarded as less than entirely necessary to the physical health of the patient, doctors must take particular care in explaining fully the risks and anticipated results. As in experimental situations, courts may impose on doctors a higher standard of disclosure in such circumstances.
10. Encouragement about optimistic prospects for the results of treatment should not allow for the misinterpretation that results are guaranteed.

11. Where a part or all of the treatment is to be delegated, patients have a right to know about this and who will be involved in their care. Consent explanations should include such information.

12. A note by the physician on the record at the time of consent explanations can later serve as important confirmation that a patient was appropriately informed, particularly if the note refers to any special points which may have been raised in the discussion.
**Consent Forms - Documentation of Consent**

**Purpose and Use**

Consideration of a form of consent to be signed by the patient should not obscure the important fact that the form itself is not the “consent”. The explanation given by the doctor, the dialogue between doctor and patient about the proposed treatment, is the all important element of the consent process. The form is simply evidentiary, written confirmation that explanations were given and that the patient agreed to what was proposed. A signed consent form will be of relatively little value later if the patient can convince a court the explanations were inadequate or, worse, were not given at all.

Apart from providing evidence that a patient consented to proposed treatment, there is another important reason for having consent forms signed. In many Canadian jurisdictions it has become a legal requirement that such a document must be completed before any surgical procedure is undertaken in a hospital.

**Essential Elements**

On the basis of experience in advising and defending its members on matters of consent, the Canadian Medical Protective Association believes a satisfactory consent form, adaptable to most situations, should be a relatively simple document such as the prototype suggested (see page 21).

**Identification and Acknowledgement of Explanations**

The form should name the patient and in general terms the nature of the investigation, treatment or operation. It should name the doctor who is to carry out the treatment. There should be included an acknowledgement by the patient that explanations have been given about the nature of the treatment, its anticipated effect, about any material risks and special or unusual risks. Mention should be made also of the patient’s acknowledgement that alternative forms of treatment or investigation have been discussed. The form should allow for acknowledgement by the patient that he or she is satisfied with the explanations and has understood them.

**Anaesthesia**

Again, as a result of its experience with negligence litigation against doctors, the Canadian Medical Protective Association continues to believe that specific consent, except where required by a statute, is unnecessary for the administration of anaesthesia for surgery. The need for written consent for anaesthesia is seen as limited because ordinarily it should be implicit in the documentation of the preanaesthetic examination by the anaesthetist that the patient was properly informed. The pre-anaesthetic visit by the anaesthetist or the anaesthetist’s delegate provides an opportunity for discussion about alternative forms of
anaesthesia which might be offered, any exclusions imposed by the patient and any particular risks which the examining anaesthetist feels may be appropriate to mention in the particular case.

Although usually the record of the pre-anaesthetic examination will adequately confirm the dialogue which occurred between anaesthetist and patient, if specific consent for anaesthesia is included on a form, care should be taken to avoid provision on the document inviting exclusions to be stated by the patient. Any such exclusions should have been agreed upon at the pre-anaesthetic examination. Failing such discussion and decision, and particularly with a form that offers opportunity for the patient to stipulate exclusions, there is greater risk the patient could impose last minute restrictions on the anaesthetist with the possibility that these might be overlooked.

**Added or Alternative Procedures**

The clause in the prototype form authorizing additional or alternative procedures requires some special comment. In their pre-operative explanations to patients, surgeons will always attempt to anticipate in advance what various conditions might be encountered and what alternative procedures might have to be added during the operation. However, not infrequently, circumstances arise which compel the doctor to consider an extension of the procedure, something which could not have been anticipated and which was not mentioned to the patient beforehand.

In these situations, the doctor may exceed the mandate given by the patient only if failure to take the additional or alternative steps would render ineffective the procedure for which the consent was given or would pose a significant risk to the health or life of the patient. If there arises need to proceed with something wholly different from that to which the patient has given consent and if it be reasonable and not harmful to delay, the patient should be allowed to regain consciousness. Then additional explanations can be given and consent sought for the different procedure. Only when something additional or alternative is immediately necessary and vital to the health and life of the patient, not merely a matter of convenience, should a doctor proceed without expressed consent.

**Delegation to Others**

The final paragraph of the prototype consent form is deemed necessary because of two sets of circumstances which are common in practice. The first is the situation where a number of physicians work as a group and where for various reasons work may be delegated to another member of the same group. The other circumstances are those found in teaching hospitals where PGY trainees and others participate in the care of patients. Delegation of work and responsibility to these post-graduate trainees is essential. They must have assigned to them increasing responsibility for reaching decisions and for carrying out progressively more difficult and complex treatments and procedures once they have shown evidence of capability.

Patients must be informed about the involvement of trainees in their care. At the same time they should be reassured about the quality of that care and the measure of supervision which will be exercised. If patients in teaching hospitals are told that other doctors may be involved
in their care, if they are given appropriate reassurances and especially if they have already met the other members of the medical team looking after them, patients will likely accede to the proposals and, most important, can never claim they did not know work might be delegated to someone else. Some clinical teachers may still have concern that if all of this is done routinely and such acknowledgements are set out on a consent form, some patients might refuse to allow the management to be delegated, insisting that their own attending doctor provide it all. This, of course, is the patient’s prerogative. If there must be difficulty, better it be resolved beforehand than to be faced later with a patient who thinks the result of treatment is less than ideal and who then claims if it had been known the treatment was to be delegated, consent would have been withheld. Under such circumstances both doctor and post-graduate trainee might be relatively defenceless.

Signatures and Witnesses

Remembering that consent forms are simply documentary confirmation of consent explanations and the patient’s willingness to proceed with what has been proposed, it is preferable to arrange for a patient’s signature on the form as contemporaneously as possible with the pre-treatment discussions. Sometimes it is convenient to accomplish this in a doctor’s office or at the bedside with the doctor present. More often, however, the signing may occur as an administrative step during the process of admission to hospital or as part of a hospital ward administrative routine. Regardless of the circumstances, the patient should be given ample opportunity to consider what he or she is signing and should not be unduly pressed or hurried.

Because of the varying circumstances under which consent forms are frequently signed, nurses or other hospital personnel may be asked to witness the signing. It should be remembered that in witnessing a signature the witness simply confirms the identity of the patient who signed the document and that the person’s mental state at the time appeared to allow for an understanding of what was signed. The role of the witness has no other legal significance. Most important, the witness to a signature on a consent form should not feel he or she has any obligation whatsoever to provide pre-treatment explanations which, in signing the form, the patient acknowledges having received. A nurse or other person witnessing a patient’s signature on a consent form does in no way attest to the adequacy of explanations which have been given by the physician. However, if a patient implies or states that he or she has been inadequately informed about the nature of the proposed treatment, a person witnessing the signature or others present should not press for the signature and the treating physician should be notified.

Some consent forms require the signature of the treating physician who, by signing, acknowledges that consent explanations have been given. Clearly, the purpose of this signature is to direct doctors’ attention to their legal obligations, obligations about which they should have been well aware without such a reminder. Although the purpose of the treating doctor’s signature may be commendable, having regard to some of the practical considerations in arranging for the completion of consent forms, it may be preferable that this requirement not be imposed. On most occasions the doctor will have held the required discussions with the patient previously and may not be readily available at the time when the form is prepared for the patient’s signature. Then, if through an administrative failure the doctor’s signature fails to appear on the form, its absence might be more harmful to the doctor’s legal interest than if the form did not call for his or her signature in the first place.
The Contemporaneous Note

A signed consent form has undoubted evidentiary value and is a specific legal requirement in many situations. However, when an informed consent is called into question, a doctor’s note on the record may be of equal or even greater usefulness for defence purposes. Courts rely heavily on progress notes if it is clear they were made contemporaneously with the events they record.

At the time when consent explanations are given it is a relatively simple matter for the doctor to note briefly some of the significant points raised in conversation with the patient. Such notations, particularly if they identify questions or special concerns expressed by the patient, can serve to validate the consent process better than any other documentation.

The note need not be voluminous or time consuming. If it records on the office or hospital chart something relevant to the discussion with the particular patient it will be much more credible in evidence than the recollections of any of the parties involved in a lawsuit. The contemporaneous progress note about consent can be invaluable and is highly recommended.
Supplements to Consent
Explanations

Because the essential element of consent is the dialogue and sharing of information as between doctor and patient, anything which can conveniently facilitate this process is desirable. Nothing can replace the pre-treatment consent discussions with the patient but sometimes these discussions can be more informative if they are supplemented by printed material which is given to the patient in advance and can be read at leisure.

For relatively standardized treatments, investigative or therapeutic procedures, background information about what is being proposed may be provided in the form of information sheets or printed brochures. This material should outline the nature of the proposed treatment or procedure, its purpose and intended outcome, and should mention significant risks and potential complications which might be of relevance to most patients. An information sheet should invite questions from the patient about the treatment and it should be clear that opportunity will be given for such questioning and for further discussion after the sheet has been reviewed.

Information sheets, brochures, and similar material may not be applicable in many circumstances under which consent is obtained but when they are used should be seen only as an adjunct and not a substitute to consent discussions. Frequently consent explanations must be tailored to the particular circumstances of the individual patient.

Because of the wide variety of circumstances under which consent forms are signed, it is preferable that the information sheet or similar document should not be an integral part of the consent form. The signing of a consent form, the acknowledgement that appropriate information has already been given, is often simply an administrative step which does not allow for adequate review of information on which patients must base their decisions for or against treatment. Documents supplementary to consent explanations should be provided well in advance of signing. From time to time when commenting about consent procedures, courts have made it clear that except in urgent and pressing circumstances patients must be given adequate opportunity to consider the implications of that to which they are consenting.

Consent explanations are sometimes supplemented in a more elaborate fashion by a videotape record of a discussion about the proposed treatment or procedure. This adjunct is probably most applicable for cosmetic surgery but may be suitable also in other circumstances.

Regardless of what supplementary methods are employed to provide patients with information prior to consent, it must again be emphasized that they can only supplement and not replace dialogue with the patient. For evidentiary purposes, a contemporaneous notation should be made confirming that the supplementary material had been provided and that after reviewing it the patient was given an opportunity to ask questions about it before consenting. Since legal actions often arise many years after clinical treatment, it is wise to keep older versions of information sheets on file in case they are required during medico-legal difficulties that arise after they are no longer in use.
Treatment in Canada of U.S. and Other Foreign Residents

It is not unusual that physicians practising in Canada are called upon to provide professional services for people who are not ordinarily resident in Canada. Often they are visitors or tourists who become ill and require urgent or emergent care. Increasingly, however, such people have come to Canada specifically to receive medical and other health care, often of a more or less elective nature. Most, but certainly not all, of that latter group have a connection with the United States, either because they are citizens or because they are ordinarily resident in that country.

Every Canadian physician should appreciate that a U.S. resident who brings legal action because of dissatisfaction with medical care received in Canada may very well seek to bring that legal action in the United States. When that happens, one of the principal issues to be determined by the U.S. court is whether, given all of the facts of the case, there is any good reason why the U.S. court should not accept jurisdiction. The issue will not be whether the court should accept jurisdiction; the issue will be whether there is any compelling reason why the court should not accept jurisdiction. The more it appears that a U.S. resident was encouraged or invited to attend in Canada for the management, or the more it appears that arrangements for the management were made while the patient was in the United States, or the more it appears that U.S. funding was involved, or the more elective the management, the greater the likelihood that the U.S. court will conclude that there is no reason that it should not accept jurisdiction.

Canadian physicians who will be participating in the management of U.S. and other foreign residents, most particularly those who have been encouraged or invited to come to Canada for care, should attempt to ensure that any resultant legal action will be brought in Canada, not in the United States or elsewhere.

Note: Effective December 2002 a revised agreement form called the Governing Law and Jurisdiction Agreement for Non-residents of Canada should be used when treating foreign patients. This form should be used in addition to the Consent to Investigation, Treatment or Operative Procedure form except in urgent cases.
(1) I, ________________________________, hereby consent to undergo the investigation, treatment or operative procedure, ________________________________, ordered by or to be performed by Dr ________________________________.

(2) The nature and anticipated effect of what is proposed including the significant risks and alternatives available have been explained to me. I am satisfied with these explanations and I have understood them.

(3) I also consent to such additional or alternative investigations, treatments or operative procedures as in the opinion of Dr ________________________________ are immediately necessary.

(4) I further agree that in his or her discretion Dr ________________________________ may make use of the assistance of other surgeons, physicians, and hospital medical staff and may permit them to order or perform all or part of the investigation, treatment, or operative procedure, and I agree that they shall have the same discretion in my investigation and treatment as Dr ________________________________.

Dated ________________________________

   day / month / year

Witness ________________________________  Patient ________________________________
GOVERNING LAW AND JURISDICTION AGREEMENT
(for Non-residents of Canada)

Note: Effective December 2002, this form replaces the consent form published in the December 1998 Information Sheet on this topic.

Governing law

I hereby agree that the relationship and the resolution of any and all disputes arising therefrom between myself and Doctor ___________________________ (as well as his or her agents, delegates or employees), including any issues related to this Agreement, shall be governed by and construed in accordance with the laws of the Province or Territory of ___________________________ and the laws of Canada applicable therein.

Jurisdiction

I hereby acknowledge that the treatment will be performed in the Province or Territory of ___________________________ and that the Courts of the Province or Territory of ___________________________ shall have exclusive and preferential jurisdiction to entertain any complaint, demand, claim, proceeding or cause of action, whatsoever arising out of the treatment. I hereby agree that if I commence any such legal proceedings, I will do so only in the Province or Territory of ___________________________, and hereby irrevocably submit to the exclusive and preferential jurisdiction of the Courts of the Province or Territory of ___________________________.

__________________________________ __________________________________
Patient’s signature Witness signature

__________________________________ __________________________________
Printed name Printed name

__________________________________ __________________________________
Date Date