POLICY

Informed Consent and Determining Capacity to Consent

STATUS:	APPROVED
Approved by Council:	June 2011
Amended:	March, 2017
To be reviewed:	March, 2022

This policy is intended to:

1) inform physicians of the requirements to obtain informed consent from patients;
2) guide physicians in Saskatchewan when determining if their patients have capacity to consent to treatment;
3) guide physicians in addressing situations where patients do not have capacity to consent to treatment; and,
4) facilitate communication between physicians, patients and their families relating to medical treatment.

It is based upon two principles:

1) physicians are required to provide patients with relevant information in order to allow their patients to decide whether they will agree to a proposed treatment; and
2) patients who have the capacity to consent will exercise their autonomy by making informed decisions about their health care.

DEFINITIONS

Capable: To be capable implies that the person is able to understand information that is relevant to making decisions and is also able to appreciate the reasonably foreseeable consequences of either making or not making a decision.

Capacity: A person has capacity if that person is capable of consenting to treatment.

Incapable: To be incapable implies that the person is unable to appreciate information that is relevant to making decisions or is unable to appreciate the reasonably foreseeable consequences of either making or not making a decision.

Interpretation: The art of taking one language and rendering it into another orally. Interpreters transpose spoken messages from one language into another, instantly and accurately, and work in real-time situations, in direct contact with both the speaker and the audience.

Translation: The art of taking written text in one language and rendering it into another in written form, conveying the message word-for-word.

Treatment is anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan.

Substitute Decision-maker is a person who has the legal authority to make decisions on behalf of an incapable person.

HCDSHCDMA - *The Health Care Directives and Substitute Health Care Decision Makers Act* - The legislation in Saskatchewan that addresses capacity to consent to medical procedures and the authority for persons other than the patients to make health care decisions for the patient in certain circumstances.

Health Care Directive – A written document signed by a patient under the authority of *The Health Care Directives and Substitute Health Care Decision Makers Act.* Such a document may provide directions respecting the care to be provided if a patient does not have capacity, may appoint a substitute decision maker to make a health care decision on behalf of a patient who does not have capacity, or both.

OBTAINING INFORMED CONSENT

The College of Physicians and Surgeons accepts the document "*Consent – A Guide for Canadian Physicians*" produced by the Canadian Medical Protective Association as an authoritative statement of the requirements for informed consent. That document, as it existed at May, 2021 is attached at the end of this document.

Physicians should use that document as a guide when seeking consent to provide treatment to patients.

The CMPA document is available at https://www.cmpa-acpm.ca/en/advice-publications/handbooks/consent-a-guide-for-canadian-physicians

PROCEDURES FOR ASSESSING CAPACITY

Determining capacity is the responsibility of the physician who will provide the treatment. The following steps, should be followed:

Step 1: Consider whether in the context of a particular clinical situation a patient is capable of providing informed consent. For example, is there:

- evidence of confused or delusional thinking;
- an appearance of an inability to make a settled choice about treatment;
- severe pain or acute fear or anxiety;
- the appearance of severe depression;
- the appearance of impairment by alcohol or drugs;
- any other observations which give rise or a concern about the person's behaviour or communication;

- evidence of significant intellectual disability;
- evidence of impairment of executive function, or mild cognitive impairment; or,
- evidence the person is unduly under the influence of another person.

Step 2: In order for a patient to have the capacity to make a decision respecting a proposed treatment, the patient must be able to understand the information that is relevant to making the decision, including:

- the conditions for which the treatment is proposed; and,
- the nature of the proposed treatment; and
- the risks and benefits of the treatment; and,
- the alternatives to the treatment, including the alternative of not having the treatment.

Step 3: If the person does not understand the information, he or she is not capable of giving consent. If the person is able to understand the information, you must go on to assess whether the person is able to appreciate the reasonably foreseeable consequences of a decision. You must be of the opinion that:

- the person is able to acknowledge that the condition for which treatment is recommended may affect him or her; and,
- the person is able to assess how the proposed treatment or lack of treatment could affect the person's life or quality of life; and
- the person's choice of treatment is not substantially based on a mental disorder such as mania, depression or delusional disorder.

Step 4: If the physician decides the person is not capable of giving consent, he or she must advise the patient of this finding and its consequences, and identify the appropriate substitute decision-maker authorized by the HCDSHCDM.

ADVANCE HEALTH CARE DIRECTIVE

If a patient who lacks capacity to make a health care decision has a valid health care directive that clearly anticipates and gives directions relating to treatment for the specific circumstances that exist, that direction prevails over the instructions of any person who would otherwise be entitled to make a health care decision on the patient's behalf. The physician has a legal and ethical obligation to follow the directions in such an advance health care directive.

If the patient has a health care directive, but that directive does not provide clear instructions respecting the treatment to be provided, and the health care directive appoints a person as a Substitute Decision-Maker to make health care decisions on the patient's behalf, then the Substitute Decision-Maker can provide consent on the patient's behalf.

Substitute Decision-makers

If a patient does not have a health care directive, the *HCDSHCDM* sets out the following hierarchy of individuals who may give or refuse consent on behalf of a patient who lacks capacity:

1. the spouse or person with whom the person requiring treatment cohabits and has cohabited as a spouse (which includes a same-sex spouse) in a relationship of some permanence;
2. an adult son or daughter;
3. a parent or legal custodian;
4. an adult brother or sister;
5. a grandparent;
6. an adult grandchild;
7. an adult uncle or aunt;
8. an adult nephew or niece.

Priority of Decision-making Between Substitute Decision-makers

1. If the patient is a child, the decision of the patient's legal custodian takes precedence over a health care decision of a non-custodial parent.

2. If there are two or more individuals in the class of individuals which is to make the health care decision on behalf of a patient, the decision of the eldest takes precedence over the decisions of other persons in that class. (If, for example, the closest relatives are children of the patient, the decision of the oldest child will prevail).

3. Where there is no nearest relative or where the physician or institution has been unable to find the nearest relative, a physician may provide necessary treatment if:

   (a) the physician believes that the proposed treatment is needed; and
   (b) another treatment provider agrees in writing that the proposed treatment is needed.

GUIDELINES

1. Ideally, where appropriate, the physician should try to obtain consensus among involved family members to assist in maintaining relationships within the family.
2. The highest-ranking person on this list, who is available, capable (similar decision-making as described above) and willing, is the substitute decision-maker for the incapable person.
3. The physician must provide the substitute decision-maker with the information that would otherwise have been given to the patient to enable him or her to make an informed decision as to consent.
4. The physician should advise the substitute decision maker of that person's obligation to act:

   (a) according to the wishes expressed by the person making the directive prior to that person's incapacity to make a health care decision, if the substitute decision-maker has knowledge of the person's wishes. Where a health care decision in a directive does not clearly anticipate and give directions relating to treatment for the specific circumstances that exist, the directive is to be used for guidance as to the wishes of the person making the directive; or
   (b) according to what the substitute decision-maker believes to be in the best interests of the person making the directive, if the proxy has no knowledge of the person's wishes.

5. A physician should consider whether the substitute decision-maker is complying with the principles set out in the *HCDSHCDMA*. If a physician is of the view that the substitute decision-maker is not acting in accordance with the *HCDSHCDMA,* the physician should take appropriate steps to try to obtain compliance with the principles of *HCDSHCDMA.* The physician should clearly express the physician's concerns to the substitute decision-maker to allow the substitute decision-maker to reconsider their decision. If after that discussion the physician remains of the view that the substitute-decision maker is not acting in accordance with the *HCDSHCDMA*, the physician should consider obtaining advice from CMPA, the College, an Ethics Board or other source of advice to assist the physician to deal with the situation.

MINORS

The *HCDSHCDMA* does not identify an age at which minors become capable of consenting to health care because the capacity to exercise independent judgment for health care decisions varies according to the individual and the complexity of the decision at hand. Providers must make a determination of capacity to consent for a child just as they would for an adult. The decision of a child who is capable of consenting to health care prevails over a conflicting decision of his or her parents.

While a parent or other custodian is able to make a health care decision on behalf of a minor who does not have the capacity to make his or her own health care decision, if that child is under the age of 16, and the physician believes that essential medical, surgical or other recognized remedial care or treatment has not been or is not likely to be provided to the child, *The Child and Family Services Act* requires the physician to make a report to a member of the Department of Social Services or the police.

ADDITIONAL INFORMATION

This document contains a summary of some of the more important provisions of *HCDSHCDMA. The full text of the Act is available from the Queen's Printer of Saskatchewan at* *http://www.qp.gov.sk.ca/documents/English/Statutes/Statutes/H0-001.pdf* *. The full text of the regulations are available at* *http://www.qp.gov.sk.ca/documents/English/Regulations/Regulations/H0-001R1.pdf*

PATIENTS WITH LIMITED ENGLISH PROFICIENCY

Patients with Limited English Proficiency – challenges for appropriate care

The literature clearly demonstrates that ineffective communication between physicians and patients due to a patient's Limited English Proficiency is a barrier to effective care, produces poor outcomes and can be frustrating for patients and physicians.

Some of the concerns identified where there is a language barrier between a patient and a physician are:

- Patients are less likely to ask their physician questions
- Physicians are less likely to probe further into symptoms of their patients
- Patients are less likely to seek care

- Patients are less likely to participate in preventative measures
- Patients are less likely to adhere to treatment, including inappropriately taking prescribed medications
- Longer hospital stays
- Increased risk of surgical errors or complications
- Patients report decreased health status
- Physicians experience difficulty dealing with the tension between what is “ideal” and what is practical or possible.

Identifying individuals who have Limited English Proficiency

- The patient states they speak little or no English.
- The patient requests an interpreter.
- The patient nods or says "yes" to all of the professional's comments and questions. This may be a culturally based demonstration of respect or it may reflect a lack of understanding.
- The patient speaks a language other than English at home. This is a strong indicator of proficiency, because the language spoken at home is the language in which the person expresses emotions and the largest vocabulary. If English is not the language used at home, then that person may lack the vocabulary for self-expression, especially regarding emotional issues, sensitive topics or health related subjects and terminology.
- The patient speaks a language other than English with friends.
- The patient’s preferred language for reading is other than English. This may indicate the patient’s limited English vocabulary. However, many professionals trained in other countries read English well because English language textbooks are frequently used for advanced education. Thus, the person may comprehend written English better than spoke English.
- The patient has a brief residence in the country. However, length of residency alone is not a good indicator of proficiency.
- It is important to remember that although a patient may have attained a high level of English proficiency, in times of extreme stress, illness and with ageing, a person's proficiency in their second language is likely to decrease and an interpreter may be required.[1]

The use of family members, friends, children and untrained individuals to interpret for a patient

A number of sources have identified concerns if a patient’s family member act as the interpreter in the discussion between the patient and the physician:

- Family members or friends may misinterpret or misrepresent medical discussions
- The use of family members or friends may compromise the patient’s privacy
- Patients may be less willing to provide information if a family member or friend is present
- The family member may be reluctant to convey embarrassing information to the patient

- There are serious risks of information being filtered either deliberately or because the family member or friend cannot interpret accurately.
- Rather than interpret, family members may tend to speak for the patient, removing the patient from the decision-making process

The literature recommends against using children as interpreters except in an emergency when there aren't other options. Children lack the linguistic and cognitive abilities to reliably interpret in technical or stressful situations. Few children will be equally fluent in English and the patient's language. In some circumstances a physician may be reluctant to ask a patient's child to relay information about an embarrassing side effect of a particular prescription.

The use of another patient can be problematic, due to issues of confidentiality and the person's ability to communicate medical concepts effectively.

Untrained interpreters may omit or add facts, substitute their own comments, or volunteer answers for the patient. They may also inject their own opinions and observations, or impose their own values and judgments as they interpret.

Principles

1. Communication is a cornerstone of patient safety and quality care and every patient has the right to receive information in a manner he or she understands. For communication to be effective, the information provided must be complete, accurate, timely, unambiguous, and understood by the patient.
2. Effective communication with patients produces better health outcomes and is more satisfying for physicians and patients.
3. Effective communication is critical in order to obtain informed consent from a patient.

The College's recommendations

1. Physicians should be aware of the resources available to provide interpretation services. Resources may be available through the Regional Health Authority or other agency.
2. When assessing the need for an interpreter, physicians should consider factors such as the urgency of the situation and the extent to which effective communication is critical to the care of the patient. Physicians may also consider whether effective communication can occur if the physician speaks more slowly, enunciates more carefully, uses plain language or asks the patient to paraphrase what the patient has been told.
3. In most cases, interpretation by telephone with a recognized interpretation service will be sufficient. There may be some circumstances where it is necessary to provide an in-person interpreter.
4. Despite the concern with the use of family members or friends to interpret for a patient, a competent patient has the right to make that choice. That should only be accepted after the patient is advised that use of an approved interpreter is recommended and information is provided about the reasons that the physician recommends the use of an interpreter. If a patient, after

being advised of the risks of not using an approved interpreter, decides to use an adult family member, or other person as interpreter, this should be recorded in the patient's health record.

5. Physicians should consider educating their staff in cultural competency. That will help to identify situations where a patient requires the assistance of an interpreter.
6. In situations where another, appropriate, physician who is fluent in the patient's language is available, a referral to that physician may be appropriate.

Available translation resources

1. This document was approved by Council March, 2017. The information provided to the College at that time was that Regional Health Authorities did not generally provide interpretation and translation services for physicians when seeing patients in their private offices.
2. The information provided to the College at March, 2017 was that some Regional Health Authorities will provide interpretation and translation services for physicians seeing a patient to obtain consent for a surgical procedure to be performed in a hospital in that health region.
3. The College of Physicians and Surgeons website offers a search function for physicians who have self-declared an ability to speak other languages. There are approximately 75 languages spoken by Saskatchewan physicians listed on that website.
4. Healthline is available by calling 411. Healthline utilizes CanTalk's services and offers interpretation in more than 100 languages. The service is free of charge to Saskatchewan patients and physicians.
5. The information provided to the College at March, 2017 was that the Regina Open Door Society may, with prior arrangement, be able to assist a physician to communicate with a patient with limited English Proficiency. The contact information for the Regina Open Door Society is 4th Floor, 2220 12th Avenue, Regina, SK S4P 0M8, 306-352-3500, http://rods.sk.ca/pages/interpreters-and-translation. Interpretation and translation services are sometimes free, sometimes negotiated with the referring "agency", sometimes paid with honorarium.
6. The information provided to the College at March, 2017 was that the Saskatoon Open Door Society may, with prior arrangement, be able to assist a physician to communicate with a patient with limited English Proficiency. Interpretation and translation services are generally arranged through the Association of Translators and Interpreters of Saskatchewan. Interpretation services require advance notice and details of the appointment are needed to book an interpreter. Personal requests may not be accepted due to limited resources. Telephone interpretation can be arranged. The contact information for the Saskatoon Open Door Society is 306-653-4464, axiao@sods.sk.ca, and http://www.sods.sk.ca/Services/TranslationServices.aspx.
7. The information provided to the College at March, 2017 was that the Prince Albert Multicultural Council may be able to provide free interpretation services, but only if both the physician and the patient are at the Multicultural Council office. Their contact information is 306-922-0400.
8. The information provided to the College at March, 2017 was that the YWCA Newcomer Centre (Prince Albert) has a language line available which can be used if the patient is at the doctor's office. A 3-way call can be done. This service can be accessed at by calling 1-866-874-3972.
9. The information provided to the College at March, 2017 was that the Multicultural Society of Moose Jaw may be able to arrange for an interpreter to provide translation services on a fee for service

basis, however this service is currently under review. The *Resettle Assist Program* will provide free interpretation services to newcomers for the first year. Their contact information is (306) 693-4677.

10. The information provided to the College at March, 2017 was that the Southwest Multicultural Association is a volunteer-run organization which has a list of volunteers who may be able to assist with translation services. Most of the volunteers do not charge for interpretation or translation services. Their contact information is 306-773-5038.
11. The information provided to the College at March, 2017 was that Réseau de Santé en français de la Saskatchewan operates the Accompagnateur program for French-speaking patients which includes trained interpreters accompanying patients to medical appointments and providing interpretation services where necessary. The service is a pilot project approved until December, 2017 and is free to patients. The service is available in Saskatoon, Prince Albert, Regina, Moose Jaw and Gravelbourg. Their contact information is 1 844-437-0373.
12. The information provided to the College at March, 2017 was that the First Nations and Metis Health Services have access to language interpretation for Dene and Cree. Services in Saskatoon are available by calling 306-655-0518 (St. Paul's Hospital) or 306-655-0166 (Royal University Hospital). In Regina, please check for availability of services in Cree by calling the Eagle Moon Health Office at 306-766-6995.
13. The information provided to the College at March, 2017 was that commercial interpretation and translation services can provide interpretation by telephone as well as translation services. The services in use in Saskatchewan include MCIS Language Solutions 1 (888) 990-9014, http://www.mcislanguages.com/interpretation/request-an-interpreter/ and CanTalk - http://www.cantalk.com/. The information provided to the College at March, 2017 was that the cost for telephone interpretation by MCIS Language solutions was $1.69 per minute and the cost for telephone interpretation services by CanTalk was $2.95 per minute.

Footnotes

[1] *Informed Consent - Multicultural Information: For Clinicians* – Queensland Health, https://www.health.qld.gov.au/consent/html/multicul_info_clin

Other resources reviewed

Parsons JA, Baker NA, Smith-Gorvie T, et al. *To 'Get by' or 'get help'? A qualitative study of physicians' challenges and dilemmas when patients have limited English proficiency*. BMJ Open 2014;4:e004613. doi:10.1136/ bmjopen-2013-004613

Joshua S. Coren JA, Filipetto FA, Weiss LB *Eliminating Barriers for Patients With Limited English Proficiency*. *J Am Osteopath Assoc.* 2009;109:634-640

Interpreting and Translating in NHS Lothian - *Meeting the Needs of People with Limited English Proficiency*. http://www.nhslothian.scot.nhs.uk/yourrights/tics/documents/interpretingtranslationpolicy.pdf

Pennsylvania Patient Safety Advisory, *Managing Patients with Limited English Proficiency*. Vol. 8, No. 1—March 2011, http://www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2011/mar8(1)/Pages/26.aspx

Overcoming the challenges of providing care to LEP patients, Issue 13 May 2015. http://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_13_May_2015_EMBARGOED_5_27_15.pdf

Saskatoon Health Region Policy: *Interpretation and Translation Services*, June 27, 2013, https://www.saskatoonhealthregion.ca/about/RWPolicies/7311-20-013.pdf#search=interpretation%20policy