Consent to Treatment

Registrants are reminded that dentists are obligated at all times to maintain the standards of practice of the profession including those published by the College. A registrant who fails to comply with a standard published by the College or the generally accepted standards of practice of the profession may be acting in a manner that could result in allegations of professional misconduct.

Contents

Executive Summary

This Standard of Practice sets out requirements for obtaining valid consent to treatment. The duty to obtain consent arises from fundamental legal, professional, and ethical obligations, which reflect the right of every patient to make informed choices about their own body and healthcare. By obtaining valid consent, dentists also help to enhance communication with patients, build trust, and manage risks arising from treatment.

This Standard of Practice addresses consent to treatment only, and not consent related to other areas of practice, such as consent for the collection, use, and disclosure of personal health information.[1]

[1] Legislative requirements for the collection, use, and disclosure of personal health information are set out in the *Personal Health Information Protection Act, 2004,* S.O. 2004, c. 3, Sched. A. Additional guidance for dentists related to personal health information can be found in applicable RCDSO resources, including (among others): the College's Practice Advisory on Release and Transfer of Patient Records.

Definitions

Key terms are defined below for the purposes of interpreting and applying this Standard of Practice. In some cases, these definitions may be specific to this Standard or area of practice, and not applicable to other College documents or areas of dentistry. Where a definition has specific or limited application to this Standard or area of practice, this will be identified in a footnote.

Treatment includes anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic, or other health-related purpose, and includes a course of treatment, plan of treatment, or community treatment plan.[2]

Capacity refers to an individual's ability to understand and use information to make a decision concerning treatment. A person has capacity to consent to treatment if they are able to understand the information that is relevant to making a decision, and can appreciate the reasonably foreseeable consequences of a decision or a lack of a decision.[3]

Emergency is a situation in which an individual is apparently experiencing severe suffering, or is at risk of sustaining serious bodily harm if treatment is not administered promptly.[4]

Express consent is direct, explicit, and unmistakable, and can be given orally or in writing.

Implied consent is consent that is not given explicitly, but which can be inferred based on the individual's actions and the facts of a particular situation (e.g., the patient nods their head in agreement).

Substitute decision-maker (SDM) is a person who may give or refuse consent to treatment on behalf of a person who lacks capacity. The *Health Care Consent Act, 1996* (HCCA) specifies who may act as an SDM on behalf of an incapable person,[5] and sets out specific requirements that they must meet when exercising their duties.[6]

Valid consent is consent that has been obtained in accordance with all applicable legal and professional obligations. Valid consent is obtained before care is provided.[7]

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[2] This definition of "treatment" is specific to the requirements for obtaining consent to treatment and is derived from s. 2(1) of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.
[3] s. 4(1) of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.
[4] This definition of "emergency" is specific to the requirements for obtaining consent to treatment and is derived from s. 25(1) of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.
[5] s. 20(1) of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.
[6] s. 20(2) of the *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sched. A.
[7] Limited exceptions for treatment in emergency situations are set out in s. 25 of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A. More information about providing care in emergencies can be found in the final section of this Standard.

Principles

1. The duty to obtain consent reflects the fundamental right of every patient to make informed decisions about their own body and healthcare.

2. Without valid consent, there can be no treatment.[8]

3. The duty to ensure that valid consent is obtained rests with the dentist proposing the treatment.

4. Dentists have a duty to provide an accurate explanation of treatment options, risks, and costs.[9]

5. Consent is a process: it begins before treatment is provided and is renewed throughout the course of treatment.

General Requirements

1. Dentists **must** ensure that valid consent has been obtained prior to administering treatment.[10]

2. Dentists **must** respect the decision of the patient or their SDM to refuse, withhold, or withdraw consent, even if the dentist disagrees with that decision.

3. Where dentists rely on staff or others to fulfill specific requirements related to obtaining consent (e.g., communicating information about the treatment being proposed), the treating dentist **must** ensure that this individual has the knowledge, skill, and judgment to fulfill this role.

4. If dentists are unsure whether the consent that has been obtained is valid (i.e., that it fulfills all applicable legal and professional obligations), dentists **must not** provide treatment until assured that valid consent has been obtained.

5. If dentists are unsure of their legal or professional obligations for obtaining consent in specific circumstances, dentists are **advised** to contact RCDSO's Practice Advisory Service or obtain independent legal advice.

[8] Limited exceptions for treatment in emergency situations are set out in s. 25 of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A. For more information about providing care in emergencies, see the final section of this Standard.

[9] RCDSO Code of Ethics.

[10] A failure to obtain valid consent to treatment could result in allegations of negligence or battery, and/or a finding of professional misconduct under *O. Reg. 853/93: Professional Misconduct*.

Requirements for Valid Consent

The *Health Care Consent Act, 1996* (HCCA) sets out the requirements that must be fulfilled in order for consent to be valid, including the information that must be communicated to the patient or their substitute decision-maker (SDM).[11] Dentists are reminded that the requirement that consent be **informed** is only one of several mandatory requirements, all of which are set out below.

6. In order for consent to be valid, dentists **must** ensure that it is:
    a. obtained from the patient, if the patient has capacity to consent to treatment, or from the patient's SDM, if the patient does not have capacity to consent to treatment;
    b. related to the specific treatment being proposed;
    c. informed;
    d. given voluntarily and not under duress or coercion; and
    e. not obtained through misrepresentation or fraud.[12]

7. In order for consent be informed, dentists **must** ensure that the patient or their SDM is provided with the following information:[13]
    a. the nature of the treatment;
    b. the treatment's expected benefits;
    c. the treatment's material risks and material side effects;[14]
    d. alternative courses of action; and
    e. the likely consequences of not receiving the treatment.

8. Dentists **must** be satisfied that the information communicated has been understood by the patient or their SDM, and take reasonable steps to facilitate comprehension where needed. For example, dentists can ask follow-up questions, encourage discussion, or consider the use of a translator when a language barrier is present.

[11] s. 11(1) of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.

[12] Unless it is not reasonable to do so in the circumstances, the HCCA (s. 12) permits dentists to presume that consent to treatment includes:

a. consent to variations or adjustments in the treatment, if the nature, expected benefits, material risks and material side effects of the changed treatment are not significantly different; and
b. consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks or material side effects of the treatment as a result of the change in the setting in which it is administered.

[13] s. 2 and 3 of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A.

[14] Dentists must use judgment when deciding which risks and side effects are to be disclosed. Based on relevant case law, dentists are advised to provide the patient with information that a reasonable person in the same circumstances would require to make a decision about the treatment. This would include disclosure of those risks and side effects that are common, even though not necessarily grave, and those that are rare, but particularly significant.

9. Dentists **must** make themselves available to the patient or their SDM upon request to respond to questions or concerns.[15]

10. Dentists **must** ensure that the patient or SDM has time to consider the information provided, ask and receive answers to any follow-up questions or concerns, and reach a decision concerning consent.

11. As part of the consent discussion, dentists **must** ensure that information concerning fees are disclosed to the patient or their SDM before treatment is initiated (e.g., the cost of treatment, any anticipated additional costs that may arise once treatment is underway, and any relevant information related to insurance coverage).[16]

Express and Implied Consent

12. While consent can be either express or implied, dentists are **advised** to obtain express consent when the treatment:
    a. is likely to be more than mildly painful;
    b. carries appreciable risk;
    c. will result in loss or impairment of a bodily function;
    d. is a surgical procedure or an invasive investigative procedure; or
    e. will lead to significant changes in consciousness.

Consent Forms

Consent forms can be a helpful way to reinforce information about the proposed treatment and support informed decision-making, however, dentists are reminded that a signed consent form is not consent itself. A consent form is only as useful as the consent discussion that accompanied it, and forms are not a substitute for the requirements set out in this Standard or the HCCA, 1996.

13. Dentists **must** ensure that they fulfill all of the requirements for obtaining valid consent as set out in this Standard and the HCCA, 1996, regardless of whether they are using supporting documents (e.g., a consent form).

14. Dentists **must** ensure that signed consent forms are retained as part of the patient's record.

[15] s. 11(2)(b) of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.
[16] This is a requirement of RCDSO to help ensure that patients are fully informed before making a treatment decision. This is not a requirement under the HCCA, 1996.

Determining Capacity

In order for consent to be valid, the individual giving or refusing it (i.e., the patient or their SDM) must be 'capable' with respect to the treatment. Importantly, capacity is not static: a person may be capable with respect to some treatments and not others, they may be capable at one point in time and not another, and capacity can be present, fade, or return with the individual's mental well-being or clarity of thought. Where dentists are unsure about an individual's capacity, they are advised to seek guidance from RCDSO's Practice Advisory Service or the Consent and Capacity Board (CCB)[17].

PATIENT CAPACITY

15. Dentists **must** ensure that the patient giving or refusing consent is capable with respect to the treatment being proposed.[18] Dentists are entitled to presume capacity unless there are reasonable grounds to believe otherwise (e.g., something in the patient's history or behaviour raises questions about their capacity).

16. Because capacity is not static, dentists **must** continue to consider the patient's capacity at various points in time and in relation to the specific treatment being proposed or administered.

17. If a patient disagrees with a dentist's determination that they are incapable of consenting to treatment, the dentist **must** advise the patient of their right to apply to the CCB for a review of the finding.

18. If a patient disputes a dentist's determination that they are incapable of consenting to treatment, the dentist **must not** provide treatment until the matter can be resolved, or the CCB has rendered a decision. To facilitate a timely resolution, dentists are **advised** to recommend that the patient submit their formal disagreement to the CCB for review.

SUBSTITUTE DECISION-MAKERS (SDMs)

19. When a patient is incapable of giving or refusing consent to treatment, the dentist **must** ensure that valid consent is obtained from the next highest-ranking person in the hierarchy of substitute decision-makers as set out in the HCCA, 1996 (see Appendix A).

[17] The Consent and Capacity Board (CCB) is a quasi-judicial administrative tribunal which operates at arm's length from the Ministry of Health. The Board convenes hearings and makes decisions under six Acts, including the *Health Care Consent Act*. The Board aims to provide timely, fair and accessible adjudication of issues relating primarily to matters of consent, capacity, and civil detention: https://www.ccboard.on.ca/scripts/english/aboutus/index.asp

[18] The *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A describes the criteria that must be met in order for an individual to be capable of giving or refusing consent: first, the person must be able to understand the information that is relevant to making a decision, and second, the person must be able to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.

20. If the highest-ranking person in the hierarchy does not satisfy all of the requirements for substitute decision-making under the legislation,[19] the dentist **must** move to the next-highest-ranking person who meets the requirements.

21. Dentists **must** ensure that SDMs understand and comply with the principles for giving or refusing consent as set out in the HCCA, 1996.[20]
    a. the SDM must give or withhold consent in accordance with the most recent and known wish expressed by the patient, while capable and at least 16 years old;
    b. if there is no known or applicable wish, the SDM must make a decision guided by the patient's best interests. [21]

22. If a patient disputes the involvement of an SDM, the dentist **must** advise the patient of their right to direct their concerns to the CCB for review.

MINORS

In Ontario, there is no fixed age of capacity to consent to treatment. This means that 'minors' (e.g., patients under the age of 18) may have capacity to give or refuse consent to treatment. The considerations that will inform an assessment of capacity of a minor are the same as those that would inform the assessment of an adult patient (i.e., is the patient able to understand the relevant information and the reasonably foreseeable consequences of a decision?)

23. If a dentist determines that a minor is capable with respect to treatment, the dentist **must** obtain consent from the minor directly, even if the minor is accompanied by a parent or guardian. However, dentists are reminded that no one under the age of 18 can enter into a legally binding contract, which means that a payment arrangement cannot be entered into with anyone under the age of 18.

Documentation

24. Dentists **must** document information regarding patient consent and capacity in-keeping with RCDSO's Dental Recordkeeping Guidelines.

[19] s. 2 of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A. Requirements include that the SDM:
    a. is capable with respect to the treatment,
    b. is at least 16 years old, unless he or she is the incapable person's parent;
    c. is not prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on their behalf;
    d. is available; and
    e. is willing to assume the responsibility of giving or refusing consent.

[20] s. 21 of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.

[21] If an SDM is not making decisions in accordance with the principles for substitute decision making set in the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A, dentists may bring a "Form G" application to the Consent and Capacity Board for review.

25. Dentists **must** use their professional judgment to determine what information to document, taking into consideration the specific circumstances of each interaction.

26. In general, dentists are **advised** that the more complicated or risky the treatment is, the more specific and detailed their documentation should be. This also applies to treatment undertaken for strictly cosmetic or aesthetic reasons.

27. At minimum, dentists are **advised** to record the following information in the patient's record for all consent discussions:
    a. the names of any individuals who participated in the consent discussion;
    b. the specific potential risks and benefits that were communicated;
    c. any risks that were communicated related to the circumstances of the patient;
    d. any risks that were communicated related to refusing, withholding, or withdrawing consent;
    e. whether consent was given or refused, and by whom;
    f. what was consented to, if anything;
    g. the date that consent was given or refused;
    h. any questions or concerns raised by the patient or SMD;
    i. any alternative treatments or options that were discussed, including no treatment; and
    j. any findings of incapacity along with the identity of the SDM, as needed.

28. When there has been a determination of incapacity, dentists are **advised** to record:
    a. the information, circumstances, or reasoning that were the basis for that determination;
    b. the advice that was provided to the patient;
    c. the name and the relationship of the person who has been identified as the patient's SDM; and
    d. whether the SDM has been given a power of attorney for personal care for the patient.

Emergency Treatment

In limited circumstances, dentists may find themselves in emergency situations where it is not possible or in the patient's best interest to obtain valid consent prior to administering treatment. For instance, this could occur in situations where a patient is incapable of communicating their consent, and where administering immediate treatment would relieve severe suffering or reduce the risk of serious bodily harm. The HCCA, 1996 sets out specific requirements that healthcare providers must meet when providing emergency treatment.[22]

29. In emergencies, dentists **must** obtain valid consent from the patient or their SDM unless:

[22] s. 25 of The *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.

a. the communication required in order for consent to be given or withheld cannot take place (e.g., because of a language barrier or disability, or because the SDM cannot be reached);
b. steps that are reasonable in the circumstances have been taken to find a practical means of enabling communication, but none have been found;
c. the delay required to find a practical means of enabling communication will prolong the suffering of the patient or put them at risk of serious bodily harm; and
d. there is no reason to believe that the patient does not want the treatment.

30. Dentists **must not** provide treatment in emergencies if they have reasonable grounds to believe that the patient, while capable and at least 16 years of age, has expressed a wish applicable to the circumstances to refuse consent to the treatment.

Appendix A: Hierarchy of Substitute Decision-Makers (SDMs)

If a person is incapable with respect to a treatment, consent may be given or refused on their behalf by a person described in one of the following paragraphs:[23]

1. The incapable person's guardian, if authorized to give or refuse consent to the treatment.
2. The incapable person's attorney for personal care, if authorized to give or refuse consent to the treatment.
3. The incapable person's representative appointed by the Consent and Capacity Board (CCB), if authorized to give or refuse consent to the treatment.
4. The incapable person's spouse or partner.
5. A child or parent of the incapable person, or a children's aid society or other person who is entitled to give or refuse consent to the treatment (this does not include a parent who has only a right of access).
6. A parent of the incapable person who has only a right of access.
7. A brother or sister of the incapable person.
8. Any other relative of the incapable person.

The SDM is the highest-ranking person set out in the above list who is also:

1. capable with respect to the treatment;
2. at least 16 years old, unless they are the incapable person's parent;
3. not prohibited by court order or separation agreement from having access to the incapable patient or giving or refusing consent on their behalf;
4. available; and
5. willing to assume the responsibility of giving or refusing consent.

[23] s. 20 (1) of The *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.