

Practice Standard- Consent

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Definitions

Consent: to acquiesce, agree, approve, assent and give permission to some act or purpose.

Informed consent: a phrase used in law to indicate that the consent given by a person has been based upon a clear appreciation and understanding of the facts, implications, and future consequences of an action. In order to give informed consent, the individual concerned must have adequate reasoning faculties and be in possession of all relevant facts at the time consent is given. In some instances, a substitute decision maker may be involved in giving informed consent.

Express Consent: consent that is given directly in explicit words, either verbally or written, by the patient/client or substitute decision maker, for a specific purpose.

Implied Consent: consent that is inferred from signs, actions, or facts or by inaction or silence. The standard that is applied to whether implied consent was obtained is based on whether a reasonable person in the same circumstances would believe that consent was given.

Intent

To facilitate appropriate assessment/examination or treatment of patient/client by ensuring that members comply with their obligations relating to consent.

Objectives

- To ensure that members and the public are aware of the mutual benefits of fully informed, voluntarily given consent to assessment/examination or treatment.
- To ensure members are aware of their existing obligations relating to consent.
- To clarify the consent requirements outlined in legislation, the case law, shared professional values and various existing College Practice Standards, policies and guidelines.
- To ensure patients/clients receive appropriate information about the nature, benefits, risks and side effects of kinesiology assessment/examinations or treatments.
- To facilitate discussion and dialogue between members and patients/clients relating to kinesiology care.

Description of Standard

Members must respect the autonomy of patients/clients and will only assess/examine or treat them with their informed consent with rare exceptions (e.g., an emergency).

Elements of Consent

Every member of the College must ensure that the patient/client or their substitute decision maker, including an authorized representative, consent to any assessment/examination or treatment or to a course of treatment that is:

1. fully informed;
2. voluntarily given;
3. related to the patient/client's condition and circumstances;
4. not obtained through fraud or misrepresentations; and
5. *where appropriate*, evidenced in a written form signed by the patient/client or otherwise documented in the patient/client record.

Consent can be written, verbal or implied. Implied consent (e.g., taking a verbal history from a patient/client) should be used with caution because it is easy for a misunderstanding to occur. For example, a patient who disrobes on request may not be consenting to all forms of touching (or, in some circumstances, any touching at all). Since it is the duty of the member to obtain informed consent, the onus is on the member to ensure that the patient/client understands and appreciates what is being asked and agrees to it.

Appropriate Discussion and Dialogue

In order to be "informed," consent to assessment/examination or treatment (including imaging), includes a discussion of the following:

1. What is the nature of the recommended assessment/examination or treatment?
2. Why should the patient/client have the assessment/examination or treatment?
3. What are the alternatives to the assessment/examination or treatment?
4. What are the effects, material risks and side effects of the proposed assessment/examination or treatment and alternative assessment/examinations or treatments?
5. What might happen if the patient/client chooses not have the assessment/examination or treatment?

In discussing the effects, material risks and side effects of the proposed assessment/examination or treatment and alternative assessment/examinations or treatments, members shall disclose improbable risks, particularly if the effects are serious. Accordingly, members shall include a discussion with patient/clients of the rare but potentially serious risk of pain or injury.

Obtaining consent is an ongoing and evolving process involving continuous discussions with a patient/client and not a single event of a patient's/client's signature on a consent form. If the member recommends a new assessment/examination or treatment, if there are significant changes in a patient's/client's condition, or if there are significant changes in the material risks to a patient/client, the member should continue the dialogue with the patient/client about the material risks, the benefits and side-effects of the recommended assessment/examination or treatment,

including potential risks that may be of a special or unusual nature, and document those discussions in the patient's/client's chart.

During discussions, members should provide patient/clients with an opportunity to ask questions concerning the proposed assessment/examination or treatment and answer questions prior to the commencement of the assessment/examination or treatment. Patients/clients may withdraw their consent to any assessment/examination or treatment at any time.

The standard of disclosure focuses on the patient/client and what a reasonable person in the patients'/clients' position would need to know to make an informed decision. Members are advised to err on the side of caution in providing comprehensive disclosure. In addition, if a patient has unique concerns (e.g., disrobing in front of a person from the opposite gender), this should be discussed as well.

Incapable Patients/Clients

Where a patient/client does not understand the information or appreciate the reasonably foreseeable consequences, he or she would be incapable of making the decision. Capacity can vary with the proposed intervention (e.g., the patient/client could be able to consent to an examination but not to a treatment plan) and over time (e.g., the patient/client has "good days and bad days").

Where the member concludes that the patient/client may not be capable of consenting to a proposed intervention, the member is expected to inform the patient/client of this finding, where feasible, and include the patient/client in the process as much as possible. The member must then (absent an emergency) obtain consent from a substitute decision maker.

Note that, as per the *Health Care Consent Act, 1996* and its regulations, only specified health care professionals may act as evaluators of capacity and make a determination of incapacity. Members do not have the authority to formally evaluate capacity and should refer to an appropriate health care professional if there is evidence that a patient/client is not capable with respect to a particular treatment or service at a particular time.

The *Health Care Consent Act, 1996* does not identify an age at which minors may exercise independent consent for health care because it is accepted that the capacity to exercise independent judgment for health care decisions varies according to the individual and the complexity of the decision at hand. Members are encouraged to seek consent from the appropriate substitute decision maker to treat children who do not have the capacity to consent to an assessment/examination or treatment.

The *Health Care Consent Act, 1996* sets out the priority of substitute decision makers and the principles that apply. The hierarchy of substitute decision makers is as follows:

1. The incapable person's guardian, if the guardian has authority to give or refuse consent to the treatment.
2. The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment.
3. The incapable person's representative appointed by the Consent and Capacity Board if the representative has authority to give or refuse consent to the treatment.
4. The incapable person's spouse or partner (which need not be a sexual partner).
5. A child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This

does not include a parent who has only a right of access and is not lawfully entitled to give or refuse consent to treatment. If a children's aid society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, it gives consent.

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.
9. As a last resort, the Public Guardian and Trustee.

The substitute decision maker who is highest on the list makes the decision unless he or she is not willing or able to make the decision, is not capable themselves, or is not at least 16 years of age (unless that person is also the parent of the patient). If two equally ranked substitutes cannot agree on a decision, then the Public Guardian and Trustee (a civil servant) makes the decision. For more information on the Public Guardian and Trustee, see:

<http://www.attorneygeneral.jus.gov.on.ca/english/>

The substitute decision maker acts as if he or she were the patient/client. The substitute decision maker is entitled to all of the information for making the decision just as the patient/client would be. The substitute decision maker is required to act in the patient's/client's best interests, taking into account any wishes expressed by the patient/client while he or she was capable.

Information Practices and Billing

The principles described above apply with some minor modifications to the collection, use and disclosure of personal health information (including patient/client records) and billing. Members will proceed only on the basis of full disclosure, patient/client choice and informed consent unless one of the recognized exceptions apply (e.g., disclosure of personal health information where permitted or required by law). See the Practice Standard on Record Keeping and the Practice Guideline on Privacy and Confidentiality for more information.

Legislation

Health Professions Procedural Code

Regulated Health Professions Act, 1991
The Professional Misconduct Regulation

The Health Care Consent Act, 1996

The Personal Health Information Protection Act, 2004.

Notation

In the event of any inconsistency between this standard and any legislation that governs the practice of members, the legislation governs.