Ethically Speaking...

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Ethically Speaking...

provides news and information from the Canadian Catholic Bioethics Institute at Assumption University.

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Decisions, Decisions – What you need to know about Consent and Capacity in Ontario

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Each and everyday we make hundreds of decisions about life. Some decisions are small, others may have a greater impact such as when we need to make decisions about our health. But what happens when a person is no longer able to understand their options or appreciate the consequences of their choices? This article highlights information that everyone should know about healthcare consent and capacity in Ontario.

What is informed consent?

Ontario law recognizes everyone has a right to refuse or agree to any treatment or medical procedure. Informed consent means that you must be provided with all the information you need to make a decision about treatment or care. It is required for anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic, or other health-related purpose. The only time consent is not required is in an emergency where someone's life may be at risk.

What information do you need to give informed consent?

Health care providers must give you the information that any reasonable person would need to decide. They need to tell you about the treatment and what it involves. They must explain the benefits, as well as the risks and side effects (both common and less common but serious). They must also provide you with information about alternative treatments if available, as well as

what would happen if treatment were refused. The healthcare provider is also required to answer any questions you may have regarding the treatment. By having this information, you can make an informed decision to consent to or refuse care.

What is 'capacity'?

The terms 'consent and capacity' are always linked because in order for consent to be valid, a person must be capable to make decisions. "Capacity" is a legal term that refers to the mental ability to make a certain decision at a particular time (where you live, what medication or treatments to take, what to do with your money, etc.). Capacity is not a single ability that people have or not have – we use different abilities to make different kinds of choices – capacity is task-specific. (Cooney et al 2004, Etchells et al 1996, Ganzini et al 2003, Moye & Marson 2007, Qualls & Smyer 2007)

According to the Health Care Consent Act (2004), assessing a person's capacity involves 2 branches:

1. The person's ability to **understand** the information that is relevant to making a decision about the treatment.

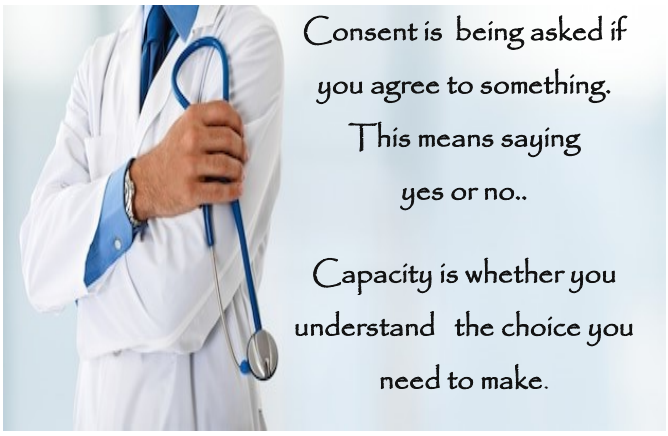
In other words, can they grasp and remember the information that is required to make the decision? Can they process and synthesize this information? An example of someone who might have difficulty with retaining or processing information could include those with dementia, traumatic brain injury, or delirium.

2. The person's ability to **appreciate** the reasonably foreseeable consequences of a decision or *lack* of a decision**.** Can the person apply the facts to him or herself?

For example, a patient who has been diagnosed with anorexia nervosa may be able to understand and intelligently discuss the nature and consequence of the illness and accept the fact that people must eat, or they may die. Despite this, the patient is not able to eat and maintains that they will be fine.

Who determines a person's capacity to make decisions?

In Ontario, the health care provider who is seeking consent is responsible to determine if a person has the capacity to make the health care decision being presented. Assessing capacity is part of every patient encounter and for the most part, the process is spontaneous and straight forward. By sharing information and ensuring the person understands their health situation and options for care, they can confirm whether they can make an informed decision. If a person is unable to fulfill part or both requirements, they lack capacity and are incapable of providing informed consent.



What Happens when a person is incapable of deciding?

It is expected that everyone has mental capacity unless there is a reason to believe they don't. The onus is on the health care provider to prove incapacity. (Etchells et al 1996, Ganzini et al 2003, Ganzini et al 2005, Ministry of the Attorney General 2005, Qualls & Smyer 2007)

A declaration of incapacity removes a fundamental freedom and right to make choices for oneself. People should only be declared incapable when it has been firmly established that they lack the ability to make decisions or are at serious risk because of their incapacity. (Silberfeld & Fish 1994, Qualls & Smyer 2007)

Because capacity can fluctuate and change over time and with the circumstance, for every new decision capacity must be reviewed. If someone becomes mentally incapable and can't safely give consent, the healthcare provider will count on their substitute decision maker to step in and help make decisions. The substitute decision maker(s), often a family member, will receive the same information as a patient.

Its important to keep in mind that incapacity is often reversible. An Illness can temporarily impair a person, but capacity can be regained upon recovery. For example, a person who is has an Infection, pneumonia, or urinary tract infection may regain the ability to consent once the illness has been treated.

Misconceptions about Capacity

In our society, people are presumed capable to make choices for themselves, unless proven otherwise. The onus is on the healthcare provider to prove incapacity. (Etchells et al 1996, Ganzini et al 2003, Ganzini et al 2005, Ministry of the Attorney General 2005, Qualls & Smyer 2007). The concept of capacity is often misinterpreted or misunderstood. The following are a few misconceptions:

1: It's not all or nothing

Capacity is not static. It may vary depending on a person's mental abilities, the complexity of decisions, and fluctuations in health. For example, a resident in long-term care may be capable of consenting to taking medication, having a BP taken, blood work, or making choices at a meal, but be incapable of understanding and appreciating the risks, benefits and alternatives to having surgery. Capacity may also vary over time due to the person's physical and psychological condition.

2: Risky decisions means you aren't capable

The requirements for capacity include the ability to appreciate, but this isn't necessarily based on whether a decision is a good or bad one; what is being assessed is the whether the decision is 'reasoned' as opposed to 'reasonable'. If someone can tell you how the reached their decision or what was important to them in making the decision, it shows they've used a logical thought process in determining their choice.

We all have the right to refuse care even if the decision does not appear in our own best interests. In such a case every effort should be made to ensure the person understands the consequences of the decision.

3: Consent can only be given by those 18 years or older

In the Health Care Consent Act (2006) capacity is not defined by age. The same concepts apply to children and adults about understanding and appreciating. If a person is able to understand the information related to the treatment and appreciate the consequences of the treatment decision, then the person can consent to the treatment. The Health Care Consent Act (2006) does stipulate however that you must be at least 16 years old to *consent on behalf of another person* (unless the other person is your child).

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Points to remember:

- Capacity is an essential component of valid consent.
- Capacity is NOT a test result or diagnosis.
- Capacity deals with the decision-making and does not depend on the actual choice made.
- Capable people can make rational decisions, based on their values, goals, knowledge and understanding of the issues facing them – they have the ability to identify and accept risks.
- Capacity is not a single ability that people have or not have – we use different abilities to make different kinds of choices – capacity is task-specific.
- Assessing capacity is not related to an illness, diagnosis or living situation. (Ex: living in a LTCH does not make an individual "globally incapable") rather it requires considering the whole person.
- There is a need to balance autonomy and beneficence. (Cooney et al 2004, Etchells et al 1996, Ganzini et al 2003, Moye & Marson 2007, Qualls & Smyer 2007)

References & Resources

Substitute Decisions Act, sections 6 and 45.

Guidelines for Conducting Assessments of Capacity, Capacity Assessment Office, Ministry of the Attorney General, May 2005.

http://provincialadvocate.on.ca/documents/en/IDC_SurvivalGuide_EN.pdf

https://www.williamoslerhs.ca/en/visiting-us/help-making-health-care-decisions.aspx#What-if-Im-found-incapable-of-making-a-treatment-related-decision

http://www.advocacycentreelderly.org/appimages/file/CBAHealth%20Care%20Consent%20&%20Advance%20Care%20Planning-2013.pdf

25 Common Misconceptions about the Substitute Decisions Act and Health Care Consent Act
http://www.acelaw.ca/appimages/file/25%20Common%20Misconceptions.pdf

Advance Care Planning and End of Life Decision-Making: More than just Documents
http://www.acelaw.ca/appimages/file/Advance%20Care%20Planning%20&%20End%2 0of%20Life%20Decision%20Making.pdf

"What really is Marriage?" Questions to ponder in Real Life Cases

Fr. Leo Walsh CSB

Case 1: John and Mary, both Catholic, have been married in the Catholic Church for ten years. Their marriage is somewhat boring, though their love-making is enjoyable enough. Mary, though, wants something more from life. At her office, she meets James, a Catholic, and they fall passionately in love. Mary divorces John and marries James civilly.

After three years, Mary and James attend a seminar on marriage, at an Anglican parish. Both come to their senses Catholic-wise and seek advice from a priest. They are told, that in their case, they could remain together so long as they live a brother/sister life. They both agree and "come back to church."

They are both happy to be practicing their faith again, but Mary really misses sexual love-making. She invites John to dinner, with James' permission and they talk together. Mary says that she and John may make love legitimately since they are still married as far as the Church is concerned. They all agree, and an arrangement is reached that John will come to Mary's home once a month for dinner and an overnight stay, while James goes to an hotel.

As far as the threesome is concerned, everything is working out well. But Mary has a question for you. She is still young enough to have a baby. May she and John use birth-control in order to keep the present arrangement going, without the complication of children?

Case 2

Anne is lesbian. She falls in love with Belle who was born male but is transitioning to female, but retains male genitalia. Belle loves Anne and they want to get married, since both are Catholic and strong believers. They go to see a local priest, who is one of the young, modern breed of arch conservatives. Without any conversation or explanation, and certainly without any compassion, he sends them away. Anne, though, has read Pope Francis, and is convinced that they might receive a more Christ-like encounter from another priest. Could you direct the couple to a more compassionate priest, and could you give them hope of marriage within the Church?

These are just a couple of real cases that beg the question what is a "real" marriage. How does the Church respond to Catholics who find themselves in such situations?

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