The Health Care Consent Act for Chiropodists and Podiatrists
G U I D E L I N E S

INTRODUCTION

On March 29, 1996 the ***Health Care Consent Act, 1996 (HCCA)*** came into force. This new Act replaced the ***Consent to Treatment Act, 1992***. The purpose of the legislation is to:

- Provide rules for consent that apply in all settings.
- Facilitate treatment, admission to care facilities and personal assistance services for incapable persons.
- Enhance individual autonomy for both capable and incapable persons.
- Promote communication and understanding between practitioners and their patients.
- Ensure a significant role for supportive family members where the patient is incapable.
- Permit intervention by the Public Guardian and Trustee only as a last resort in decisions on behalf of incapable persons.

The obligation to obtain an informed consent is unchanged in the ***HCCA***. As before, a chiropodist or podiatrist who proposes a treatment must not administer it, and must take reasonable steps to ensure that it is not administered, without consent. The consent must be obtained from the patient, if he or she is capable, or from his or her substitute decision-maker, if he or she is incapable.

TREATMENT

The ***HCCA*** defines treatment as:

> *Anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health related purpose, and includes a course of treatment or plan of treatment.*

A course of treatment is a series or sequence of similar treatments for a particular health problem. A plan of treatment is developed by one or more health practitioners, deals with one or more of the patient's health problems (both present health problems and problems the patient is likely to have in the future given their current health condition), and provides for the administration of various treatments or courses of treatment.

Treatment does not include:

- The assessment of a person's capacity with respect to treatment, admission to a care facility or a personal assistance service.
- The assessment for the purpose of the ***Substitute Decisions Act, 1992***, of a person's capacity to manage property or for personal care or the assessment of a person's capacity for any other purpose.
- The assessment or examination of a person to determine the general nature of the person's condition.
- The taking of a health history.
- The communication of an assessment or diagnosis.
- The admission of a person to hospital or another facility.

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- A personal assistance service*.
- A treatment that in the circumstances poses little or no risk of harm to the person**.
- Anything prescribed by the regulations as not constituting treatment.

* Personal assistance service is defined as "assistance with, or supervision of, hygiene, washing, dressing, grooming, eating drinking, elimination, ambulation, positioning or any other routine activity of living".

** Note that even where the treatment poses "little or no risk of harm" the common law still applies to require consent to be obtained. Also, the chiropodist or podiatrist may "opt in" to the Act by deciding to proceed as if the low risk treatment were included in the definition.

"HEALTH PRACTITIONER"

Health practitioner includes regulated health professionals and any other category of person prescribed in the regulations.

PRINCIPLES OF CONSENT TO TREATMENT

1. Elements required for consent
   a. There can be no treatment without consent.
   b. The patient must be capable with respect to the proposed treatment and must have given consent, or if the patient is incapable with respect to the proposed treatment, the person's substitute decision-maker must have given consent.
   c. Consent must relate to the proposed treatment.
   d. Consent must be informed.
   e. Consent must be given voluntarily.
   f. Consent must not be obtained through misrepresentation or fraud.

2. A consent is considered to be "informed" if before giving it the person received information about the matters that "a reasonable person in the same circumstances would require in order to make a decision about the treatment", and the person received responses to his or her requests for additional information about those matters.

3. The matters referred to in 2 are:
   a. The nature of the treatment.
   b. The expected benefits of the treatment.
   c. The material risks of the treatment.
   d. The material side effects of the treatment.
   e. Alternative courses of action.
   f. The likely consequences of not having the treatment.

4. Consent may be expressed or implied.

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CAPACITY

Under the Act capacity is determined not by age or physical abilities but by the person's ability to understand the information that is relevant to making a decision about the proposed treatment, admission or personal assistance service, and the ability to appreciate the reasonably foreseeable consequences of a decision or lack of a decision. A person is presumed capable unless the health practitioner has reasonable grounds to believe the person is incapable. (For more information please see the College's "**Guidelines for Members When Treating Incapable Patients**").

SUBSTITUTE DECISION-MAKERS

If consent is to be sought from a substitute decision-maker, it must be done so in order of priority as follows:

a. The guardian of the person, if the guardian has authority to give or refuse consent to treatment.
b. The person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to treatment.
c. A representative appointed by the Consent and Capacity Board.
d. A spouse or partner.
e. A child or parent of the person.
f. A parent with access rights only.
g. A sibling.
h. Any other relative.
i. The Public Guardian or Trustee if there is no one else or if two equally ranked SDMs cannot agree.

A person on the list may serve as a SDM only if he or she:

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 person or acting as their SDM;
d. is available; and
e. is willing to assume the responsibility.

EMERGENCIES

Under the Act treatment may be administered without consent if there is an emergency, ie. the person is apparently experiencing severe suffering or is at risk of sustaining serious bodily harm if treatment isn't administered promptly. However, emergency treatment may be continued only for as long as is necessary to find the SDM or until the patient is able to give or refuse consent. There can be no emergency treatment if the practitioner has reasonable grounds to believe it is against the wishes the person expressed while capable and at least 16 years old.

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Treatment may also be administered without consent to an apparently capable person in an emergency if the communication required in order for the person to give or refuse consent cannot take place because of a language barrier or disability, reasonable steps to find a practical means of communication have been taken but no such means have been found, the delay required to find a means of communication will prolong the person's suffering or put them at risk of serious bodily harm and there is no reason to believe they do not want the treatment.

RECORD KEEPING

Practitioners must note key findings and events relating to consent in patient's records. The following should be recorded:

- A finding that a patient is incapable in relation to a proposed treatment, including the basis for the finding.
- The name of an incapable patient's substitute decision-maker and his or her relationship to the patient.
- The fact that the member has carried out the college Guidelines relating to consent. This includes the fact that the member informed the patient of the finding of incapacity, asked the patient if they have a power of attorney or guardian, informed the patient of the name of their substitute decision-maker, and explained their right to appeal the finding of incapacity to the Consent and Capacity Board.
- The consent or refusal, including a summary of the information provided to the patient and substitute decision-maker. Written consent forms must be retained in patients' records.
- Where, in an emergency, the member treated a patient without consent, the Act requires the following to be noted: If the patient is incapable, the member must record his or her opinion that (a) there is an emergency and (b) the delay required to obtain a consent or refusal on the patient's behalf will prolong the patient's apparent suffering or put the patient at risk of sustaining serious bodily harm. If the patient is apparently capable, the member must record his or her opinion that (a) there is an emergency, (b) the communication required for the patient to give or refuse consent cannot take place because of a language barrier or the patient's disability, (c) reasonable steps have been taken to find a practical means of communication but no means have been found, (d) the delay required to find a practical means of communication will prolong the patient's apparent suffering or put the patient at risk of sustaining serious bodily harm, and (e) there is no reason to believe the patient does not want the treatment.

PROTECTION FROM LIABILITY

A practitioner is not liable if:

- Treatment is administered after a consent was given that the practitioner believes, on reasonable grounds and in good faith, to be sufficient.

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- Treatment is not administered because of a refusal that the practitioner believes on reasonable grounds and in good faith, to be sufficient.
- Treatment is withheld or withdrawn in accordance with a treatment plan that the person has consented to.
- An emergency treatment is administered without consent or withheld in accordance with the Act.

FIVE BASIC STEPS TO HEALTH CARE CONSENT

Step 1 - Determine capacity

Determine if the person is capable of consenting to the proposed treatment. Is the person able to understand the information relevant to making a decision about the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision?

Step 2 - If Person is Capable, Obtain Decision from Person

If the person is capable with respect to the proposed treatment, obtain an informed consent or refusal. Give information to the person about the nature of the treatment, its expected benefits, alternative courses of action, material risks and side effects and the likely consequences of not having the treatment that a reasonable person in the same circumstances would require in order to make a decision. Provide any additional information that the person requests.

Step 3 - If Person is Incapable, Determine if Emergency

If the person is incapable with respect to the proposed treatment, determine if he or she is apparently experiencing severe suffering or is at risk of sustaining serious bodily harm if he treatment is not administered promptly. If so, determine if it is reasonably possible to obtain a decision from a substitute decision-maker or whether the delay required to do so will prolong the person's apparent suffering or put the person at risk of sustaining serious bodily harm.

Inform the person of the finding of incapacity if the person is old enough and sufficiently aware to understand the information, or the person objects to the treatment when it is proposed, or the person objects to the substitute decision-maker. (See the College's Guidelines for Members when Treating Incapable Patients.)

If the person is apparently capable but communication about consent cannot occur because of language barrier or disability, try to find a practical means of enabling communication. If the delay required to find a practical means of communication will prolong the person's apparent suffering or put the person at risk of sustaining serious bodily harm and there is no reason to believe the person does not want the treatment, administer the treatment.

Do not treat if reasonable grounds exist to believe the person, while capable and at least 16 years old, expressed a wish applicable to the circumstances to refuse treatment.

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Step 4 - Identify Substitute Decision-Maker

If the person is incapable, give the person the information about the consequences of the finding of incapacity required by the College.

Identify the appropriate substitute decision-maker from the prioritized list in the Act. If no substitute decision-maker exists or is available, capable and willing to assume responsibility, or if equally ranking substitute decision-makers cannot agree, contact the Public Guardian and Trustee.

Step 5 - Obtain Consent from Substitute Decision-Maker

Give information to the substitute decision-maker about the nature of the proposed treatment, its expected benefits, alternative courses of action, material risks and side effects and the likely consequences of not having the treatment that a reasonable person in the same circumstances would require in order to make a decision. Provide any additional information requested by the substitute decision-maker.

If the substitute decision-maker consents, administer the treatment. If the substitute decision-maker refuses, do not administer the treatment.

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