Canadian Psychiatric Association
Dedicated to quality care
Association des psychiatres du Canada
Dévouée aux soins de qualité

POSITION PAPER

Informed Consent to Treatment in Psychiatry

Grainne Neilson, MD, MRCPsych, FRCPC, LLM[1]; Gary Chaimowitz, MB ChB, FRCPC[2]; Joaquin Zuckerberg, BA, MA, LLB, LLM[3]

A position paper developed by the Canadian Psychiatric Association Committee on Professional Standards and Practice and approved by the CPA's Board of Directors on May 21, 2014.

Introduction

The Canadian Psychiatric Association (CPA) first published a position paper on Consent in Psychiatry in 1980,[1] prepared by Dr C H Cahn, and later published a revised version in 1988,[2] prepared by Dr J Arboleda-Flórez.

Although many aspects of these papers remain true to the principles of prudent and sound psychiatric practice, there are several reasons that the CPA has chosen this time to articulate a refined position on consent to treatment in psychiatry. First is the enduring and fundamental position that people with mental illness are active and contributing members of our society who possess rights under the law and who are entitled to claim those rights, which includes the right to decide what happens to their bodies. All mentally capable people have the right to make autonomous decisions for their lives based on free and informed consent. Second, in recent decades, scientific advances in the understanding of psychiatric disorders and their treatments have enabled psychiatrists to approach decisional capacities in a more evidence-based manner. Third, the influence of modern media (especially the Internet) has resulted in a populace that is more broadly informed (but not necessarily better, or more fully, informed) about their treatment options, and who, therefore, may be susceptible to influence by medical consumerism. As a consequence, psychiatrists have a duty to ensure that a capable, appropriately informed and fully transparent approach to consent to treatment is occurring. Lastly, even though various provincial statutes and legislative regulations have evolved, as well as certain developments in Canadian case law, this has left many psychiatrists wondering how to reconcile their legislated duties with their ethical obligations in the realm of consent.

It is for these reasons that the CPA is issuing this revised position paper.

This paper was prepared for the Professional Practice and Standards Committee of the CPA and reflects a consensus among committee members and psychiatric experts regarding applicable principles and practices related to consent to treatment in psychiatry. It is intended as a review of the clinical, legal and ethical

[1] Staff Psychiatrist, East Coast Forensic Hospital, Dartmouth, Nova Scotia.

[2] Head of Services, Forensic Psychiatry, St. Joseph's Healthcare, Hamilton, Ontario; Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University, Hamilton, Ontario.

[3] Assistant Professor, Department of Psychiatry, Dalhousie University, Halifax, Nova Scotia.

principles that underlie consent to treatment decisions in psychiatry to provide practical guidance to psychiatrists when they are considering issues related to consent to treatment, when performing capacity evaluations (to consent to treatment), and when they are engaged in the process of consent. It is intended to guide, not regulate, practice in this area. Ultimately, patient factors, relevant provincial statutes, precedent legal cases, the psychiatrist's clinical judgment and consultation with colleagues will determine how psychiatrists proceed in individual cases.

Throughout this article, the term treatment refers to activities that form part of the psychiatrist–patient relationship for which consent is ordinarily required. As such, consent to treatment encompasses permission for all modalities of the assessment processes, diagnostic investigations, and procedures and (or) ongoing monitoring for same, as well as physical, medical or psychotherapeutic interventions. Consent and the mature minor, and consent to research related to psychiatric practice are discussed briefly, but are not the main focus of this paper.

The Position of the CPA Regarding Consent to Treatment

In recognition of the ethical importance of informed consent, the CPA affirms the following statements:

- The CPA considers the appropriate assessment of consent to treatment to be legally, ethically and clinically compelling. Psychiatrists must be thoroughly familiar with the elements of consent as well as the legislated requirements for consent within their province or territory of practice, irrespective of their area or focus of practice or research, and they should be appropriately guided by these.
- Communication is necessary if informed consent is to be realized. Psychiatrists must provide patients with the information they need to allow them to make informed decisions about their medical care, and should seek ways to facilitate whatever exchange of information may be necessary to allow their patient to make an informed decision. Psychiatrists must answer any questions to the best of their ability and in accordance with evidence-based practice.
- From an ethical standpoint, informed consent is a process of communication, whereby a patient is enabled to make informed and voluntary decisions about accepting or declining medical care. Concurrently, there are important legal procedural aspects to informed consent that should not be overlooked. Psychiatrists must recognize that a signed consent document does not ensure that the process of informed consent has taken place in a meaningful way or that the ethical requirements have been met. Psychiatrists should be prepared to engage in consent to treatment discussions on an ongoing basis, and appropriately document the contents of these conversations as part of the permanent medical record.
- Psychiatrists must respect the autonomous decisions of capable patients, including the right to accept or reject any medical care recommended. This means that psychiatrists must appropriately assess issues of autonomy and capacity, taking into consideration any external constraints or psychopathology that may impact these issues.
- Psychiatrists should ascertain, where possible, and respect, the treatment wishes of an incapable patient as they were expressed before the patient became incapable (for example, through an advance directive, living will or proxy designation). When informed consent by the patient is not possible, and prior treatment wishes are not clearly known, an appropriate substitute decision maker should be sought to represent the patient's treatment wishes or best interests.
- Psychiatrists should appreciate that in some circumstances respect for the autonomy of people with mental illness may need to be balanced with the psychiatrist's ethical obligations of beneficence, nonmalevolence and serving justice. This includes situations where there is a need to protect the patient or others from serious and imminent harm, or when the patient's appreciation of their right to receive adequate treatment is substantially impaired.
- Psychiatrists must demonstrate an awareness of the decisional capacities of children and the need to balance the developing competencies of children, and the role of families in medical decision making. This includes adopting a developmentally appropriate approach to communicating with children that is also respectful of their parents, family and caregivers.
- Research on subjects who have a psychiatric illness raises serious ethical and legal concerns. Before proceeding with research, informed consent from the subject or proxy must be obtained. Psychiatrists have a special duty to ensure that patients with

mental illness are capable of providing free and informed consent to psychiatric research, and that those who are incapable are not exploited as research subjects. The ethical principle of justice applies: incapable subjects should be neither deprived of the potential benefits of research nor required to bear a disproportionate burden of research.

Discussion

The Nature of Consent

Consent is a complex concept, especially in the medical context. The dictionary definition of consent is "to give permission for something to happen; to agree to do something."[3, p 368] The etymology of the word consent (from the Latin word *consentire*, taken from *con* = together; *sentire* = feel)[3, p 368] describes the intention of consent. There should be a harmony of feeling, or joining of sentiment, between the parties when the permission is granted—in other words, a mutual agreement.

Medical consent has been compared to a contractual arrangement between the doctor and patient, whereby the patient agrees to undergo specific assessment, diagnostic or therapeutic measures and the physician undertakes to exercise their expertise, experience and skills within the limitations set out by both parties.[4] Central to any contract is the requirement that there be a mutual understanding of, and agreement about, the expectations of each party. However, in the medical context, the relationship between the parties is somewhat unique—it is characterized by the placement of trust and confidence in the physician as it pertains to health care decisions (called the fiduciary relationship). This demands that the physician behave with a high degree of integrity (called the fiduciary duty).[5, p 135] This duty is predicated on the ethical values of autonomy, honesty, fairness, respect and nonmaleficence, and on benevolence of the physician and the patient's expectation that the physician will act as a trusted adviser. A fiduciary relationship is one characterized by trust, mutuality and collaboration as it relates to medical decision making.

In psychiatry, as in other branches of medicine, informed consent is an agreement that is based on an appropriate understanding and appreciation of the information necessary to make the decision. It is generally thought of as a free act of the mind, and it is usually accompanied by some degree of reasoned mental deliberation. By law, patients must give their permission before a physician may proceed with treatment, except in circumscribed situations.

The Ethical Foundations of Consent

The primary ethical foundation of informed consent is the principle of respect for personal autonomy and (or) self-determination. This is based on the belief that everyone has an inherent worth and dignity, which is preserved by allowing them the freedom to set their own life agenda and make their own choices based on their own values and belief system.

Difficulties may arise when the ethical value of respect for autonomy comes into conflict with other medical ethical values, such as beneficence (acting in the best interests), nonmaleficence (doing no harm) and fairness (the just distribution of health care resources), particularly when the decisions of a capable patient appear to conflict with their overall welfare and best interests. In general terms, as a society, we tend to prioritize personal autonomy over other ethical values and defer to the wishes of a mentally capable person, even in cases where the medical team believes that (s)he is acting contrary to their own interests. However, autonomy is a complex concept in bioethics and has many variations.[6] The notion of supported autonomy (that is, to support autonomy in the long term, it may be necessary to compromise autonomy in the short term) may permit benevolent actions or those that serve justice in the short term if they are undertaken to preserve patient autonomy in the longer term. Such compromises do not violate medical ethical principles; however, any infringement on a person's autonomy and (or) right to self-determination should always be exercised with particular caution.

Obtaining informed consent for psychiatric treatment, for participation in medical research, and for participation in teaching exercises involving students and residents is an ethical obligation that is often reflected in legislative requirements. Psychiatrists should understand the ethical principles underlying consent to treatment issues and they must be thoroughly familiar with the legislated elements of consent to treatment within their province or territory of practice, irrespective of their area or focus of practice or research, and should abide by these legislated duties.

Failure to Obtain Consent and Withdrawal of Consent

Failure to secure appropriate consent before treating, or unwarranted infringements on patient autonomy can involve multifaceted liability, including, but not limited to, negligence (where consent is inadequate), criminal liability (where no consent is given), the tortuous liabilities of assault and battery, professional discipline and (or) revocation of hospital privileges.

The requirement of informed consent may be suspended or limited by being overridden by another obligation. Many other ethical obligations can, in certain circumstances, override or set limits on the requirement to obtain informed consent. For example, issues related to public safety may set limits on interventions that a patient may refuse or choose. The rights of others not to be harmed may sometimes take priority over a person's right to refuse psychiatric treatment.

Consent neither binds the patient to accept treatment nor removes their right to withdraw consent at any time. If during the course of treatment a patient withdraws their consent, then the physician must halt the treatment, unless the medical evidence suggests that terminating it would either be life-threatening or pose immediate and serious problems to the health of the patient. This was acknowledged in a decision of the Supreme Court in 1993, *Ciarlariello v. Schacter*,[7] concerning consent being withdrawn during the course of a cerebral angiogram. Similar scenarios may apply in psychiatry where, for example, stopping medication abruptly may result in the onset of an acute withdrawal syndrome or delirium.

Types of Consent

Consent can be express, tacit, implied or presumed.[8] Express consent includes informed consent and covers all aspects of consent that are actively expressed by the patient.[8] Express informed consent is considered to be the optimal type of consent because it implies meaningful knowledge and understanding, as well as an active decision-making process. In contrast, tacit consent is expressed in a passive or silent manner (from the Latin verb *tacere*, meaning to be silent), and implies a passive process lacking in active mental deliberation. Implied consent results from implications drawn from a person's behaviour (such as calling mobile crisis lines or summoning an ambulance) from which consent may be inferred. Presumed consent describes the concept that clinicians may make certain assumptions based on the general theory of human good and rational will,[8] particularly in cases of emergency. It presumes that the physician will provide treatment according to the patient's (perceived) best interests, except in instances where there is valid reason to believe that the patient would otherwise refuse such a treatment (for example, an advance directive to the contrary).

An exception to the rule of informed consent occurs when a patient effectively waives their right to give it. This can take the form of refusing to consider information necessary for an informed decision, or simply refusing altogether to make any decision. Waivers should not be accepted complacently, without some concern for the causes of the patient's desire not to participate in the management of their care.

The Process and Procedure of Consent

Physicians should not conflate the procedure of consent (the consent form) with the process of consent. Informed consent is not necessarily formed (the signed consent form) consent.

The process of consent is the dialogue that facilitates adequate disclosure of relevant information, and promotes appropriate understanding of the relative merits of, and reasonable alternatives to, the treatments proposed. Express consent requires a meaningful exchange of information that starts at the moment of first contact between doctor and patient, and continues during the course of the treatment relationship.[9]

The procedure of consent is the record of that process, through a consent form or through proper documentation of the consent discussion. This documentary evidence of consent is nothing more than evidence of the procedure of consent at a moment in time. It is not the consent itself.[4] In 1993, in a case arising from Ontario (*Ciarlariello v. Schacter*), the Supreme Court of Canada acknowledged this distinction, noting,

> Consent is not referable to a precise moment in time but rather it is a relationship that exists between a doctor and patient. That is to say, consent is a process, not an instant in time.[10, p 137]

Consent may be written or oral. While written consent is optimal, documented verbal consent usually suffices for all but the most invasive treatments, such as electroconvulsive therapy (ECT) or psychosurgery, which may be better suited to the use of a consent form. Verbal consent discussions should be documented in the medical record, including: the fact of the discussion; the major points of content of the discussion, treatment and prognosis; any special concerns raised by the patient; the decision communicated by the patient; the physician's assessment of the patient's capacity to consent to treatment; and the degree of voluntariness.

Flowing from the understanding of consent as a process is the clinical imperative for psychiatrists to periodically review, revise, renew (and appropriately document) consent discussions to ensure that evolving circumstances have been addressed. This includes consideration of any new elements that may have arisen, such as: the evolution of the condition for which treatment is being provided; the treatment effects; the development of alternative treatments; the evolving

nature of the treatment relationship; changes in the patient's life circumstances; and consideration of the manner in which capacity may change over time.

Consent Decisions Must Be Informed

Rozovsky[11] has usefully provided a general outline of the type of information that physicians should discuss with patients concerning treatment authorizations, which has been annotated below to increase the relevance to psychiatrists:

- The nature and purpose of the proposed treatment; that is, what specific treatment modality is being proposed (for example, psychotherapy, pharmacotherapy and ECT) and why? What specifically is involved in the treatment (for example, oral or intramuscular medication and psychological methods)? How often and for how long (for example, weekly for 10 sessions)?
- The likely benefits and probable risks of the proposed treatment; that is, what is the treatment supposed to accomplish? This includes information regarding material and special risks that are likely to affect the patient's consent, and a realistic assessment of the possible benefits that may accrue to the patient.
- Reasonable alternatives to treatment that exist, if any; for example, what is the range of available treatments?, and an evaluation of what is reasonable, given the totality of the patient's circumstances. Such discussions should be evidence-based and at all times free from external pressures or commercial influences.
- The impact of treatment on the patient's lifestyle; for example, will the medication cause sexual dysfunction? Can the patient drive or operate heavy equipment while taking this medication? Does the medication require a modification of exercise, diet or drinking habits? Will the patient require time off work?
- Economic considerations related to the treatment; for example, will the patient's medical plan or insurance cover the cost of treatment? Will treatment impact the patient's ability to access services, programs and housing? Will the treatment affect the patient's future earning potential or insurability?
- The consequences of refusing treatment; for example, what are the likely outcomes if the person refuses treatment? Can the person appreciate the potential outcomes that might ensue as a consequence of such a refusal?
- The person who will perform the treatment; for example, will the person obtaining consent be the same person as the one delivering the treatment? Who else is on the treatment team and what is their area and (or) level of expertise?

From an examination of this list, it may appear to Canadian psychiatrists that some of these items are impractical and well beyond the limits of any necessary consent discussion. However, for patients, many of these considerations are of prime importance in their decision making, and in general, psychiatrists should endeavour to give their patients the information that the average person in similar circumstances would desire to make an informed decision.[12] Most provincial and territorial mental health legislations incorporate some of these elements into their declarations of capacity to consent to treatment. Not only is canvassing these issues the law (*Reibl v Hughes*), it is the ethically correct way to proceed.[13]

The Elements of Consent

While consent may be considered permission or a contractual arrangement between doctor and patient, it is clearly more than this. Several Canadian legal scholars have set forth elements that are desirable if consent is to be valid and legally binding.[14–16]

Ideally, consent should include the following elements:

- is voluntary
- requires adequate disclosure of information
- demands proper material representation
- should be appropriately communicated
- must be specific to the treatment
- can only be provided by mentally capable and (or) legally competent persons

While informed consent is primarily an ethical imperative, most legislated statutes in Canada concerning consent to treatment integrate these concepts to a greater or lesser degree, and seek to balance medical ethical principles with fundamental human rights and freedoms.

These elements (and relevant case law interpreting same, annotated for psychiatrists) will be reviewed, in turn, below. Psychiatrists must be thoroughly familiar with the elements of consent as well as the legislated requirements for consent within their province or territory of practice, irrespective of their area or focus of practice or research, and, by these, they should be appropriately guided.

Voluntary

Consent should be voluntary and free from conditions, circumstances or external influences that may limit, influence or control choice. Many conditions may conflict with voluntariness and render patients vulnerable to consenting to treatment they do not desire (for example, legal requirements to submit to psychiatric counselling or treatment; religious or cultural constraints that restrict personal choice; institutional prescribing restrictions that limit the autonomous choices of prisoners; social service funding that limits the funding of treatment that are available to a person reliant on, for example, social assistance). Coercion, fear of reprisal, improper promise of reward, undue influence or misrepresentation can never form the basis of informed consent. It should go without saying that certain conflicts in the physician–patient relationship are entirely unacceptable and (or) unethical and incompatible with voluntary consent (for example, a sexual relationship with a patient). Other conflicts may be excused or waived by a patient who is well informed (for example, prescribing a drug manufactured by a company from which grant funding is also received). Psychiatrists must be cognizant of any limitations on voluntariness that may affect consent and be prepared to fully air these considerations with their patients.

Particular care and attention should be paid when seeking consent from especially vulnerable people, such as children, the elderly and the intellectually disabled. Vulnerable people may feel unable to exert their right to withhold consent, and may simply acquiesce to maintain harmony. Others, such as involuntarily detained patients (through civil commitment or forensic detention), are also in a vulnerable position when their liberty depends on their recovery. Many have committed acts of violence toward themselves or others in the context of acute illness, and will not usually be released into the community until they are mentally stable and adherent to treatment.

Psychiatrists should also be cognizant of the effect that previously administered medication, or previously ingested intoxicants, may have on voluntariness. Obtaining consent from a patient who is sedated or otherwise severely affected by a drug or intoxicants should be avoided wherever possible.[17]

Adequate Disclosure of Information

Although adequate disclosure of risk is only one criterion needed for valid consent, issues related to disclosure have, nevertheless, been the focus of much case law in Canada. Prior to 1980, the amount of information that physicians had to disclose to their patients to obtain a valid consent was uncertain, with courts relying on what a reasonable physician would disclose. In other words, the standard in deciding what to tell the patient was that of the physician's own judgment. However, in 1980, the Supreme Court of Canada rendered two landmark decisions (*Hopp v. Lepp*[18] and *Reibl v. Hughes*[19]) that related to the duty of disclosure and the requirement of informed consent. Although surgical cases, these decisions are applicable to every branch of medicine, including psychiatry, and have had a profound effect on medical consent issues in Canada by setting a modified objective standard of disclosure.

In *Hopp v. Lepp*, a case that originated in Alberta, the Supreme Court of Canada considered whether a patient who suffered permanent damages following a hemi-laminectomy had, in fact, given informed consent to the procedure. It should be self-evident that consent is valid (and thus provides protection to the surgeon against civil tort liability) only if the patient has been sufficiently informed to enable the patient to make a choice about whether to submit to a procedure. Prior to this case, it was unclear precisely how much disclosure of information was required for consent to be considered valid. The *Hopp v. Lepp* Supreme Court of Canada decision articulated the extent and scope of the duty of disclosure. In particular, the Supreme Court of Canada said that physicians should answer any specific questions posed by the patient about the risks involved in undergoing a procedure and should, without being questioned, disclose the nature of the proposed procedure, its gravity, any material risks and any special or usual risks attendant on the performance of a procedure.[20]

The later *Reibl v. Hughes* Supreme Court of Canada ruling further clarified and expanded this duty of disclosure. In this case, the appellant, Mr. Reibl, underwent a carotid endarterectomy procedure shortly before his retirement. The procedure left him hemiplegic. The patient claimed that had he been apprised of the risk of stroke that he would not have consented to the procedure. Building on the position already articulated in the *Hopp v. Lepp* decision, the Supreme Court of Canada revisited the issue of disclosure and stated that the

> objective standard would have to be geared to what the average prudent person, the reasonable person in the patient's particular position, would agree to or not agree to, if all material and special risks of going ahead with the surgery or foregoing it were made known to him.[21, p 899]

Thus *Reibl v Hughes* replaced the age-old traditional standard of disclosure of what a reasonable physician would disclose with a new standard of what a reasonable patient would want to know. This is the modified objective standard.

Nobody, least of all the Supreme Court of Canada, expects clairvoyance from psychiatrists in determining the information patients may wish to receive before making treatment decisions. However, when negotiating the aims and outcomes of treatment, psychiatrists must consider the diversity of patient lifestyles, including cultural issues, religious and (or) spiritual beliefs, and personal ambitions and (or) goals. Then they must voluntarily disclose information that may impact these domains. It should be self-evident that psychiatrists must devote sufficient time and attention to the individual clinical and personal circumstances of the patient to be able to appreciate the issues that may be important in the patient's decision making. Delegating aspects of the physician–patient relationship to another clinician runs the risk of being unaware of concerns that may be germane to the patient's decision making. It is important that the person proposing the treatment obtain the consent, preferably directly.

Certain Canadian provinces (for example, Ontario and British Columbia) have seen fit to enact legislation pertaining specifically to informed consent and the duty of disclosure in the health care context, intended as a codification of the common-law rules regarding informed consent as enunciated in the leading case of *Reibl v. Hughes*. Other jurisdictions have not yet done so, and the CPA urges them to act to assure transparency and accountability for all concerned.

Proper Material Representation

Proper material representation means that the psychiatrist must not misstate or misrepresent any material information. Patients have the right to be informed of material or significant information (within the limits of fallible knowledge) regarding proposed treatments, and psychiatrists are obliged to provide patients with the information necessary to make such a determination. Material information includes information pertaining to risks that would be sufficiently serious as to influence the patient's decision making, were the risk to happen (materialize). This may include, for example, sedation, sexual dysfunction, weight gain or tremor. Special risks are those risks unique to a particular treatment that have the potential for serious or irreversible consequences, if they occur. This would include, for example, tardive dyskinesia, corrected QT prolongation, and (or) dyslipidemias associated with certain neuroleptics; hypothyroidism or renal dysfunction associated with lithium; and agranulocytosis associated with clozapine.

Appropriate Communication

Psychiatrists assure the effectiveness of a consent discussion by focusing on the patient's actual understanding of the information that is communicated to them. The physician should present the information that someone in the patient's situation needs to know to make a truly educated decision. The information should not be an exhaustive list of every conceivable thing that may go wrong. This may be facilitated by providing literature or other teaching tools that are targeted to a lay audience, such as patient pamphlets or videos; however, personal transmission of relevant data should be the aim. The patient should have an opportunity to ask questions and to receive understandable answers.

Communication should recognize diversity of culture, language, literacy and verbal skills present within the Canadian population. Interpreters may be necessary for non-English speakers, and a translator skilled in medical terminology is the ideal for the purpose of transmitting accurate information. Translation should not be left to family members, as they may withhold information from a patient to protect him or her from hearing bad news. In such cases, incomplete or misleading information may be all the patient receives, and the physician will not realize that information was not effectively or completely communicated. However, a patient's desire to be accompanied by a support person, family member or patient advocate during such a discussion should be willingly accommodated.

In emergency situations, or when the patient is acutely ill or in pain, the patient may be less capable of receiving, interpreting or communicating information. The medical facts must be explained carefully and deliberately to the patient and to family members or others invited into the discussion by the patient, as the urgency of the situation allows.

Authorization Specific to the Issue

Capacity to consent to treatment is not a global determination: it is task-specific. Psychiatrists must ensure that their patients receive information specific to the treatment that is being proposed. In some circumstances, the same patient may be capable of consenting to one intervention but not another. For example, a person who is incapable of consenting to psychiatric treatments may still be able to consent to, or to refuse, medical treatments, surgical interventions or other invasive procedures. In this sense, the notion of a sliding scale in the assessment of capacity can be

supported, but only when the mental processes required for understanding and appreciation of the complexity of a proposed intervention differs significantly from those required for another.

Legally Competent

The term competence is sometimes used interchangeably with the term capacity, but they are different concepts. Competence is the degree of mental soundness legally required to make decisions about a specific issue or to carry out a specific task (in this case, consenting to treatment). Competence is a legal state, not a medical one. Competence implies that the person has "the capacity to understand and act reasonably"[5, p 65]; however, capacity is but one aspect of legal competence. Other legal exigencies of competent decision making include jurisdiction and age (see below).

Where the issue of competence is contested on the grounds of incapacity, it is ultimately the responsibility of specially appointed review panels or judge(s) to decide whether that person's mental capacity is sufficient to meet the legislated criteria for legal competence (and hence that their stated wishes should be respected). The starting point in law is that all adults are presumed to be mentally capable and legally competent to make treatment decisions unless determined otherwise by a court or review tribunal of proper jurisdiction.

Psychiatric evidence is often central in assisting courts in arriving at competency decisions, but it is rarely the only evidence on which they rely. For example, the courts may rely solely on testimony of the patient, or on testimony of other people who know the patient or who are involved in the person's care.

Unlike medically assessed capacity (see below), legal competence cannot be present in degrees: courts and review panels adjudicating competence must take a dichotomous approach when deciding whether a person is competent to carry out a specific task or to make a decision regarding a certain issue.

Psychiatrists should be prepared to appropriately defend their medical opinion regarding the manner in which psychopathology has resulted in functional deficits that are sufficiently significant that the person cannot meet the demands of a treatment decision-making situation, weighed in light of its potential consequences. To do this, they must be aware of the legislated criteria related to consent to treatment in the jurisdiction in which they are practicing, and they must be able to apply the legal tests to the facts of the particular case, at an appropriate standard of proof. Declarations of incapacity to consent to treatment should be supported by medical evidence that meets a civil standard of proof (that is, balance of probabilities or other standards as articulated).[22, p 760] This standard of medical evidence is necessary because the consequences of being deprived of the right to consent to treatment can be significant and enduring.

Mentally Capable

The dictionary definition of capacity is "the ability or power to do or to understand something."[3, p 255] Like the volumetric assessment of the capacity of a vessel, mental capacity is not a measure of information that is actually held (that is, the fullness of the vessel); it is a measure of the potential for same (that is, how large the vessel is). Mental capacity is the assessment of a person's potential to receive, process, hold, understand and apply information to their situation that would enable decisions relevant to a certain issue at a specific point in time.

In general terms, capacity is decision-specific; relates to the functional task of the specific decision; and requires an understanding of the relevant information and an appreciation of the consequences of making (or failing to make) a decision.[23] It is easily seen that capacity is a clinical assessment, appropriately conducted by clinicians. The requirement to formally assess capacity to consent to treatment is codified in most provincial mental health legislations. It should be assessed by clinicians who have relevant knowledge and experience regarding the mental functions that are required to carry out such specific tasks in accordance with statutory requirements.

Psychiatrists are reminded that all patients, including those with psychiatric illnesses, are presumed to be capable of deciding to accept or reject treatment until deemed otherwise—the presumption of capacity can be displaced only by evidence to the contrary. The onus is on the psychiatrist to meet the evidentiary requirements of incapacity; it is not for the patient to prove the presence of capacity.[22, p 760]

A patient's capacity to consent to treatment may be compromised by numerous mental factors that limit their ability to exercise a choice. This would include (but not be limited to) certain symptoms of psychosis, dementia, intellectual disability, states of confusion, certain symptoms associated with severe mood disorders, substance intoxication and head injury. However, the mere presence of a mental disorder does not equate with treatment incapacity. Further, a patient's lack of insight into third-party risks should not be conflated with their lack of insight into their own treatment needs, and is not, in and of itself, a reason to make a finding of lack of decision-making capacity.[24]

Attempts have been made in academic circles to identify specific criteria or standards for capacity assessment,[25] and numerous standardized instruments have been developed for this purpose.[26] Most require not only the cognitive ability to process, retain and understand the relevant information but also the ability to rationally manipulate information, the ability to apply the relevant information to one's present circumstances and the ability to appreciate the consequences of the decision.[26] For example, the Aid to Capacity Evaluation,[27] developed in Ontario, assesses the appreciation of disorder and treatment, and understanding of informed consent, but may represent a standard that is higher than legislated criteria. Standardized instruments are nonetheless proxies to the issues at hand.

A person who is psychiatrically assessed as lacking the capacity to consent to treatment may be referred for a competency hearing (usually before a review board), essentially an appeal of the psychiatrists finding, and may need to have someone appointed to represent their interests at such a hearing.[28] The decisions of consent and capacity boards may be reviewed (and overturned) by appellate courts if there are reasonable grounds. The manner in which these matters are heard and reviewed varies from province to province, depending on each province's mental health legislation. For example, Quebec does not have consent and capacity boards; hearings take place in appellate court, and only a judge of the Superior Court may review (overturn) such decisions.

In a case that was not without some controversy among Canadian psychiatrists[29,30] (*Starson v. Swayze*[22]), the Supreme Court of Canada, in 2003, considered the criteria for determining how capacity to consent to treatment should be defined, assessed and defended before review tribunals.[29, p 3] Professor Scott Starson (also known as Scott Jeffery Schutzman) is a physicist with schizoaffective disorder who was detained at a secure psychiatric facility in Ontario in 1998 following a finding of Not Criminally Responsible on account of mental disorder for uttering death threats. Starson reportedly acknowledged that he had mental health issues, but refused to accept his condition as an illness. He also refused to consent to the course of medications that his physicians recommended for fear that it would diminish his thinking. He would have accepted psychotherapy but no medication. Two psychiatrists, including Dr Swayze, declared Starson incapable of consenting to treatment. Starson applied to the Ontario Consent and Capacity Board for a review, who confirmed the finding of treatment incapacity on the basis that Starson did not recognize that he was ill and that he needed treatment, and so was not able to appreciate the risks and the benefits related to treatment. Following various appeals to superior courts who each overturned the Board decision, Starson's psychiatrists appealed to the Supreme Court of Canada seeking to have the original Board decision of incapacity to consent to treatment upheld. In 2003, the Supreme Court of Canada published its decision upholding the finding that Starson had the capacity to accept or refuse treatment.[22]

The central issue before the Supreme Court was whether Starson was mentally capable of deciding whether to accept or reject the treatment proposed by his psychiatrists. In deciding this case, the Supreme Court indicated that capacity involves two criteria[31]:

- The patient must be able to *understand* [emphasis added] the information that is relevant to making a treatment decision. This requires the cognitive ability to process, comprehend and retain the relevant information.
- The patient must be able to *appreciate* [emphasis added] the reasonably foreseeable consequences of the decision or lack of one. This requires that the patient be able to apply the relevant information to his or her circumstances, and to be able to weigh the foreseeable risks and benefits of a decision or lack thereof.

As with all Supreme Court of Canada decisions the words "able," "appreciate" and "understand" were chosen deliberately and carefully and signify specific legal concepts: "able" speaks to capacity to understand and appreciate, not to actual understanding and appreciation. Similarly, the appreciation test is more stringent than the understanding test as it includes both a cognitive and affective component,[22, p 735] and implies an ability to evaluate the totality of the circumstances and apply them to one's own situation.

The Starson decision clarified that the following are not, ipso facto, proof of incapacity: the mere presence of a mental disorder; adhering to contrary views about the prescribed diagnosis; disagreeing with the proposed treatment, and (or) making decisions that seem unwise or contrary to one's own best interest.[22, p 767–775] Even patients who do not acknowledge their diagnosis may be deemed capable of consenting to treatment as long as they acknowledge the manifestations of the illness.

Critics of the Starson decision argue that rational decision making is critical to any decisional capacity and that Starson's right to autonomy of decision making should have been balanced with his right to receive adequate care and the right to be well.[30] However, the

crux of the Starson decision is that capable people are allowed to make unreasonable, wrong and even foolish treatment decisions[32] to the point of risking their own health and well-being, as long as they appropriately understand the risks of not undergoing treatment.

Substituted Consent

Inherent mental factors that limit choice should not deprive a person of access to appropriate medical treatments that may improve their functioning or alleviate their suffering. Instead, that person's incapacity should be recognized and someone else should be appointed to make treatment decisions on their behalf.

When a patient is not capable of making treatment decisions a substituted judgment based on prior informed consent (advanced directives or living wills) can be made with confidence, if care has been taken beforehand to learn and properly document the patient's wishes. This signals the importance of early communication so that what a patient would choose in a developing situation is known, such that it remains possible to respect the self-determination that informed consent represents. Living wills are not legal documents in Quebec, but are taken into consideration when determining the wishes of a person who has become incapacitated. Quebec civil law allows for a *Mandate in Anticipation of Incapacity*, which serves a role similar to advance directives. The current *Mandate in Anticipation of Incapacity* is renamed the Protection Mandate in Quebec's new *Code of Civil Procedure* which is expected to come into force in 2016. In parallel, in December 2015, Quebec's *Act Respecting End-of-Life Care* will come into force and with it a new regime for advance medical directives.

Prior expressed wishes of a capable patient who later becomes incapacitated should be respected as much as possible.

In instances where no advance directive has been made, a substitute decision maker should be identified to provide a decision based on what the patient would have wanted, assuming they have some knowledge of what the patient's wishes would have been. If the patient's wishes are unknown, the substituted decision maker must make decisions according to the best interests of the patient.

If the patient has previously executed an advance directive, that document should guide the selection of a surrogate decision maker or the specific decisions made by the surrogate or both, depending on the nature of the advance directive. In cases where no such directive has been executed, the hierarchies for the appropriate choice of substitute decision maker are explicitly stated in most provincial mental health legislations.

A transiently incapacitated patient may regain capacity, especially when emerging from the influence of alcohol, drugs or hospital-administered analgesics or sedatives. If a patient regains capacity, the duty of informed consent returns to the patient and the role of the proxy in informed decision making is extinguished. This is why reassessment of the patient's capacity is essential. Of note, in Quebec, categorical refusal of treatment by a patient determined to be incompetent supersedes consent to treatment from substitute decision makers, necessitating recourse to the courts.

Consent and Minors

The capacity to consent to medical treatment does not necessarily arrive at any specific age, and the evolving capacity of adolescents for self-determination is recognized in common law (except in Quebec, where matters of consent to treatment are determined by the province's Civil Code).

While provincial jurisdictions within Canada vary regarding the statutory age of majority (for example, 19 in British Columbia, New Brunswick, Newfoundland and Labrador, Nova Scotia, the Yukon, Nunavut, and the Northwest Territories; 18 in the remainder of the country)[33, p 205] it is clearly recognized that below these statutory ages, certain minors are indeed capable of making independent informed treatment decisions. This assessment is usually based on their emancipation from parental control and guidance, their cognitive competence, their emotional and social maturity and the voluntariness of the deci sion.[33, p 210–218] Any young person who is judged to be sufficiently mature enough to understand the nature and consequences of a decision may consent to their own treatments. This is the mature minor doctrine. On a practical level, psychiatrists should seek the opinion of minors in keeping with their degree of maturity.

Consent to Research

Research on subjects who have a psychiatric illness raises serious ethical and legal concerns. Consent to psychiatric research will be the focus of a separate position paper. Before proceeding with research, informed consent of the subject or proxy must be obtained. However, in general terms, researchers must be particularly sensitive to the issue of capacity and its assessment, especially when the research may involve little or no benefit to the patient. Psychiatrists have a special duty to ensure that patients with mental illness are capable of providing free and informed consent to psychiatric research, and that those who are not

capable are not exploited as research subjects.[13] The Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans[34] (which is not legislation) refers to research involving incompetent individuals and talks about consent from the authorized third party, but does not say anything about the determination of incompetency or the appointment of an authorized third party, presumably leaving this to the laws of the provinces. The ethical principle of justice applies: incapable subjects should not be deprived of the potential benefits of research, but neither should they be required to bear a disproportionate burden of research. Research differs from treatment, and researchers must make it abundantly clear that their primary focus is not necessarily patient well-being. Public accountability demands that all research publications explicitly address the informed consent process, the assessment of capacity and the risks and burdens for research participants. This transparency and accountability are vital to allow the research community to retain the trust if the public, and for the progress of science.[35]

Summary

Patients have a right to be informed and actively involved in their health care. Fundamental to a person's dignity and autonomy is the right to make decisions about their psychiatric treatment, including their right to refuse unwanted treatments, providing that the refusal is a capable one. It is important that psychiatrists have an awareness of the ethical underpinnings of consent and the legislated requirements related to consent, including precedent cases. Consent may change over time and for different conditions and circumstances. Consent must be an ongoing process.

References

1. Cahn CH. Consent in psychiatry [position paper]. Can J Psychiatry. 1980;25(1):78–85.
2. Arboleda-Flórez J. Consent in psychiatry [position paper]. Can J Psychiatry. 1988;33(5):314–318.
3. Soanes C, editor. Oxford English dictionary. 2nd ed. Revised. Oxford (GB): Oxford University Press; 2003.
4. Rozovsky LE. The Canadian law of consent to treatment. 2nd ed. Toronto (ON): Butterworths; 1997. p 1.
5. Coughlan S, Yogis JA, Cotter C, et al. Canadian law dictionary. 7th ed. New York (NY): Barron's Educational Series Inc; 2013.
6. Post SG, editor in chief. Encyclopedia of bioethics. 3rd ed. New York (NY): Macmillan Reference, USA; 2004. p 248–251.
7. *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119.
8. Lepping P. Consent in psychiatry. Psychiatr Bull. 2003;27:285–289.
9. Geutheil TG. [letter to the editor]. Hosp Community Psychiatry. 1993;44(10):1005.
10. *Ciarlariello v Schacter*, [1993] 2 S.C.R. 119, 15 C.C.L.T. (2d) 209 at p 137 per Cory J.
11. Rozovsky L. The Canadian law of consent to treatment. 2nd ed. Toronto (ON): Butterworths; 1997. p 12–16.
12. Rozovsky L. The Canadian law of consent to treatment. 2nd ed. Toronto (ON): Butterworths; 1997. p 16.
13. Neilson G. The 1996 CMA code of ethics annotated for psychiatrists. Can J Psychiatry. 2002;47(8 Insert):1–10. Canadian Psychiatric Association position paper.
14. Rozovsky L. The Canadian law of consent to treatment. 2nd ed. Toronto (ON): Butterworths; 1997. p 6.
15. Gray JE, Shone MA, Liddle PF. Canadian mental health law and policy. Markham (ON): Lexis Nexis Canada; 2008.
16. Picard E, Robertson G. Legal liability of doctors and hospitals in Canada. 3rd ed. Scarborough (ON): Carswell; 1996. p 55.
17. Kaiser HA. Lecture notes "Essential points in capacity evaluations". Mental Disability Law. Halifax (NS): University of Dalhousie Department of Psychiatry; 2003 Oct 14.
18. *Hopp v. Lepp* (1980), 112 D.L.R. (3d) 67.
19. *Reibl v. Hughes* (1980), 114 D.L.R. (3d) 1.
20. *Hopp v Lepp* (1980), 112 D.L.R. (3d) 67 at p 81 per Laskin C.J.C.
21. *Reibl v. Hughes* (1980), 114 D.L.R. (3d) 1 at p 899 per Laskin C.J.C.
22. *Starson v. Swayze* 2003 SCC 32 [2003] 1. S.C.R. 722.
23. Silberfeld M. Capacity assessment: Ontario. In: Bloom H, Schneider R, editors. Law and mental disorder: a comprehensive and practical approach. Toronto (ON): Irwin Law; 2013. p 1066.
24. Skipworth J, Dawson J, Ellis P. Capacity of forensic patients to consent to treatment. Aust N Z J Psychiatry. 2012;47(5):443–450.
25. Roth L, Meisel A, Lidz C. Tests of competency to consent to treatment. Am J Psychiatry. 1997;134:297–284.
26. Sturman E. Capacity to consent to treatment and research: a review of standardized assessment tools. Clin Psychol Rev. 2005;25:954–974.
27. Etchells E, Sharpe G, Elliott G, et al. Bioethics for clinicians: 3. Capacity. CMAJ. 1996;155(6):657–661.
28. Resnick PJ, Sorrentino R. Forensic issues in consultation–liaison psychiatry. Psychiatric Times. 2005;13(14):1.
29. Goldbloom D. Psychiatry and the Supreme Court of Canada [editorial]. [Canadian Psychiatric Association] Bulletin. 2003 Aug. p 3.
30. O'Reilly R, Solomon R, Grey J. Clinical liberty outcomes—an exchange of views on what constitutes reasonable review of treatment capacity. Research Insights of the Regional Mental Health Care London and St Thomas. 2009;6(2):1–10.
31. *Starson v. Swayze*, 2003 SCC 32, [2003] 1 S.C.R. at p 761 per Major J.
32. Koch, Ont. Gen. Div., 1997; approved Starson, SCC 2003 at p 759 per Major J.
33. Downie J, Caulfield T, Floud C. Canadian health law and policy. 2nd ed. Markham (ON): Butterworths; 2002.
34. Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council. Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans. 2014 Dec.
35. Weilie S, Berghmans R. The inclusion of patients with severe mental illness in clinical trials. CNS Drugs. 2006;20(1):67–83.

Notes