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The Canadian Law of Consent to Treatment, Second Edition

Lorne E. Rozovsky

Toronto: Butterworths Canada Ltd., 1997, 161 pp.

Reviewed by Jasmine M. Ghosn[†]

The Canadian Law of Consent to Treatment is intended for use by both health care professionals and lawyers. It provides an understanding of the legal implications that arise when a patient agrees to receive treatment, and includes several examples of some of the practical problems that raise consent issues for health professionals. Rozovsky begins by skillfully incorporating the elements developed by common law and legislation into a carefully tailored consent process that fits logically and practically with the various stages of a treatment relationship. He also provides a careful analysis of all the criteria legally required for the obtainment of a valid consent and includes several clinical examples to illustrate how these elements come to play in the delivery of health care.

Rozovsky identifies several circumstances that require special considerations or a modification of the law of consent. For example chapter two discusses situations in which it is either impractical or impossible to obtain consent from a patient. These include, among others, medico-legal emergencies and therapeutic privilege. As well, a discussion in chapters four and five explains the issues related to mental disability, children and adolescents. In other chapters, Rozovsky identifies several treatment contexts which raise controversial consent issues. These include sterilization, abortion, genetic screening, AIDS testing and tissue donation. Chapter seven covers issues related to the right to refuse treatment, with examples of recent legislation dealing with health care proxies and advance directives.

Rozovsky provides many practical suggestions for health professionals that can easily be incorporated into practice so that consent problems can be avoided. For example, chapter eight

[†] B. Sc., LL.B. anticipated 1998 (Dalhousie).

provides guidelines regarding the use of consent forms, telephone consents, and other useful suggestions. In addition, chapter ten provides recommendations and case examples on how health professionals can take a proactive approach to preventing consent problems. Finally, the appendices provide sample forms and documents that can be referred to by health professionals and lawyers who are developing consent forms, living wills, and Jehovah's Witness alert cards. The book is clearly an excellent reference for hospital staff and administrators in acute care facilities who are developing protocols and quality assurance or risk management measures related to patient consent to treatment.

Throughout the book, Rozovsky identifies legislation and case law which may apply in circumstances related to consent to treatment. He also identifies areas where the law is silent. While Rozovsky does not set out to provide every legislative enactment or case related to consent law, the book can serve as an original source for lawyers practising in the area of health law.

One significant flaw of the book is that its focus is geared towards those issues which are associated primarily with the acute care institution, and does not provide the same amount of guidance to health professionals in other settings such as rehabilitation, long term care and home care. Additionally, Rozovsky begins by identifying how the issue of consent "brings into conflict the goal of the health field to care and treat, with the goal of law to uphold the right of the individual not to be treated" (at vii), but he does not go into depth to explain what this really means. In avoiding such an analysis, the book fails to recognize the changing nature of health care and it assumes that the ultimate "goal of health care" is the same for all health professionals practising in various settings.

In my view, it is not only important to ask, "what is consent?" (which is something that Rozovsky does explain and distinguish from the consent process), but it is also important to ask: "what are the goals of health care?"; "what is treatment?"; and "how do the goals of health care and treatment conflict with legal rights of patients?". The reason it is important to ask these questions is that the answer to each of them may vary from one profession to the next, from one health care setting to another, and from one form of treatment to another. Without going into such an inquiry, the legal profession may be left believing that all health professionals in all

health care situations think alike regarding goals of health care. In addition, it is possible to ignore the fact that the conflicts which exist between the goals of health care and the legal rights of patients may vary in different contexts.

For example, the goals of health professionals who have specialized in rehabilitation may be to maximize individuals' physical, social and psychological independence. In those situations, rehabilitation professionals merely act as facilitators as the aim is to "empower" people with disabilities to take control over their bodies. Rehabilitation goals can in fact be more consistent with the *Charter of Rights and Freedoms* than health care goals in acute care settings. The rehabilitation goal of maximizing independence requires active participation and "risk taking" by the patient who must push his or her limits in the pursuit of independence.

Although Rozovsky does not explicitly define the term "treatment", he states that it is something that people are "subjected to" (at viii) as they "submit" to specific diagnostic, medical or surgical measures (at 1). Sterilizations, abortions, emergency care, research done on humans, genetic screening, AIDS testing, the taking of blood samples, etc. are forms of treatment which involve a patient taking a passive role as the caregiver does something invasive (i.e. performs a procedure) on his or her body. The goal of the law of consent is based on that patient's right to determine what, if anything, is done to his or her body. It must be noted, however, that "treatment" in a number of circumstances is not necessarily invasive or detrimental to the bodily integrity or liberty of individuals.

Treatment may involve teaching patients how to use mobility aids such as wheelchairs or walkers. In these cases, the rehabilitation professionals' role is to educate and assist the patient in developing skill and proficiency in using the mobility aid. Unlike most medical and surgical treatments which patients "submit" to, the training in the use of a mobility aid requires active participation on the part of the patient. In fact, the success of the treatment largely depends on the motivation of the patient and how much effort the patient puts into the treatment process. Also, the training in the use of the mobility aid is not always seen as "invasive treatment" or even interfering with the patient's right to liberty because the "treatment" in and of itself can be liberating and almost analogous

to someone learning how to ride a bike or learning how to ski. Also, unlike a medical procedure which involves “control” by the practitioner over the patient’s body, rehabilitation measures often involve the gradual increase of control by the patient over his or her own body.

In another example, a team of professionals may be required to do a home visit to assess what needs to be put in place to accommodate a person’s care needs at home. What is being invaded is the privacy of the patient and his or her family, not the bodily integrity of the patient.

Rozovsky reminds us that patients have the “right to be free from bodily interference from others” (at 93) and consent laws are aimed at dealing with the conflict which arises between the “goal of health care to treat” and the right of the patient to be free from interference from others. What Rozovsky does not tell us is that the conflict between the health goal and a patient’s legal rights in the acute care context may be different from the conflicts which arise in the rehabilitation or home care context. In addition, the consent issues which arise may also be different. For example, in rehabilitation or home care setting, the patient’s right to autonomy and independence can conflict with that same patient’s right to safety. Interestingly both of these rights are protected under section 7 of the *Charter* which guarantees the right to both “liberty” and “security”.

It is important to keep in mind that litigation in health care has largely resulted from events that occurred in acute care settings. In fact, both *Reibl v. Hughes*¹ and *Hopp v. Lepp*², which are the leading cases in Canada on the law of consent to treatment, involved invasive surgical procedures. Courts have had very little, if any, opportunity to develop the law of consent to treatment outside of the acute care context. Rozovsky attempts to provide several examples of situations that occur in health care settings to demonstrate how consent issues arise for health professionals and to show how the law may apply. Unfortunately, most, if not all, of these examples involve events which occur in acute care settings. Health professionals who practise outside the traditional medical

¹ [1980] 2 S.C.R. 880, 114 D.L.R. (3d) 1, 33 N.R. 361, 14 C.C.L.T. 1.

² [1980] 2 S.C.R. 192, [1980] 4 W.W.R. 645, 112 D.L.R. (3d) 67, 13 C.C.L.T. 66.

model may require different legal considerations related to the consent process. It may be that acute care institutions require more guidance in this area due to the higher frequency of litigation in that setting; however, with health care delivery moving towards deinstitutionalization and with patients and families having to become more and more responsible for their health care needs, it is possible that new consent issues will arise.