RCDSO | Royal College of Dental Surgeons of Ontario

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STANDARD OF PRACTICE

The Royal College of Dental Surgeons of Ontario's Standards of Practice set out legal, professional, and ethical obligations that apply to dentists practising in Ontario. Standards of Practice support dentists and protect the public by communicating the College's expectations for the profession.

Consent to Treatment

RELATED RESOURCES

- Information on Consent to Treatment
- Consent to Treatment Checklist

CONTENTS

EXECUTIVE SUMMARY

This Standard of Practice sets out requirements for obtaining consent to treatment. The duty to obtain consent arises from fundamental legal, professional, and ethical obligations, which reflect the right of every patient to make informed choices about their own body and healthcare. By obtaining the patient's full and informed consent, dentists also help to enhance communication with patients, build trust, and manage risks arising from treatment.[1]

This Standard of Practice is supported by companion resources which provide supplementary information and guidance, including an FAQ and infographic.

DEFINITIONS

Key terms are defined below to assist with interpreting and applying this Standard of Practice. In some cases, these definitions are drawn directly from legislation and are not applicable to other College documents or areas of dentistry. Where a definition is drawn directly from legislation or has limited application to this Standard or area of practice (i.e., consent to treatment), this is identified in a footnote.

[1] This Standard of Practice addresses consent to treatment only, and not consent related to other areas of practice, such as consent for the collection, use, and disclosure of personal health information (PHI). Legal requirements for PHI are set out in the *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Sched. A, and additional guidance can be found in applicable RCDSO resources.

Treatment includes anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic, or other health-related purpose, and includes a course of treatment, plan of treatment, or community treatment plan.[2]

Capacity refers to an individual's ability to understand and use information to make a decision concerning treatment. A person has capacity to consent to treatment if they are able to understand the information that is relevant to making a decision, and can appreciate the reasonably foreseeable consequences of a decision or a lack of a decision.[3]

Emergency is a situation in which an individual is apparently experiencing severe suffering, or is at risk of sustaining serious bodily harm if treatment is not administered promptly.[4]

Express consent is direct, explicit, and unmistakable, and can be given orally or in writing.

Implied consent is consent that is not given explicitly, but which can be inferred based on the individual's actions and the facts of a particular situation (e.g., the patient nods their head in agreement).

Substitute decision-maker (SDM) is a person who may give or refuse consent to treatment on behalf of a person who lacks capacity. The *Health Care Consent Act, 1996* (HCCA) specifies who may act as an SDM on behalf of an incapable person,[5] and sets out specific requirements that they must meet when exercising their duties.[6]

PRINCIPLES

The following principles form the foundation for the requirements set out in this Standard:

1. The duty to obtain consent reflects the fundamental right of every patient to make informed decisions about their own body and healthcare.

2. Treatment cannot be provided without first obtaining consent.[7]

3. The duty to ensure that consent is obtained rests with the dentist proposing the treatment.

4. Dentists have a duty to provide an accurate explanation of treatment options, risks, and costs.[8]

5. Consent is a process: it begins before treatment is provided and is renewed throughout the course of treatment.

GENERAL REQUIREMENTS

1. Dentists must ensure that consent has been obtained prior to administering treatment.[9,10]

2. If dentists are unsure whether the consent that has been obtained is valid (i.e., that it fulfills all applicable legal and professional obligations), dentists must not provide treatment until assured that valid consent has been obtained.

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[2] This definition of "treatment" is specific to the requirements for obtaining consent to treatment and is derived from s. 2(1) of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A.

[3] s. 4(1) of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A.

[4] This definition of "emergency" is specific to the requirements for obtaining consent to treatment and is derived from s. 25(1) of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A.

[5] s. 20(1) of the *Health Care Consent Act*, *1996*, S.O. 1996, c. 2, Sched. A.

[6] s. 20(2) of the *Health Care Consent Act*, *1996*, S.O. 1996, c. 2, Sched. A.

[7] Limited exceptions for treatment in emergency situations are set out in s. 25 of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A. For more information about providing care in emergencies, see the final section of this Standard.

[8] RCDSO Code of Ethics.

[9] Limited exceptions for treatment in emergency situations are set out in s. 25 of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A. For more information about providing care in emergencies, see the relevant section of this Standard of Practice and the Consent to Treatment FAQs.

[10] A failure to obtain consent to treatment could result in allegations of negligence or battery, and/or a finding of professional misconduct under O. Reg. 853/93: Professional Misconduct.

3. If dentists are unsure of their legal or professional obligations for obtaining consent in specific circumstances, they are advised to contact RCDSO's Practice Advisory Service or obtain independent legal advice.

4. Dentists must respect the decision of the patient or their SDM to refuse, withhold, or withdraw consent, even if the dentist disagrees with that decision.[11]

OBTAINING CONSENT

The *Health Care Consent Act, 1996* (HCCA) sets out the requirements that healthcare providers must fulfill when obtaining consent to treatment, including the information that must be communicated to the patient or their substitute decision-maker (SDM).[12] Dentists are reminded that the requirement that consent be "informed" is only one of several requirements, all of which are set out below.

5. When obtaining consent to treatment, dentists must ensure that it is:[13]
   a. obtained from the patient, if the patient has capacity to consent to treatment, or from the patient's SDM, if the patient does not have capacity to consent to treatment;
   b. related to the specific treatment being proposed;
   c. informed;
   d. given voluntarily and not under duress or coercion; and
   e. not obtained through misrepresentation or fraud.[14]

6. For consent to be "informed", dentists must ensure that the patient or their SDM is provided with the following information:[15]
   a. the nature of the treatment;
   b. the treatment's expected benefits;
   c. the treatment's material risks and material side effects;[16]
   d. information about alternative courses of action; and
   e. the likely consequences of not receiving the treatment.

7. Dentists must be satisfied that the information communicated has been understood by the patient or their SDM and take reasonable steps to facilitate comprehension where needed. For example, dentists can ask follow-up questions, encourage discussion, or consider the use of a translator when a language barrier is present.

8. Dentists must make themselves available to the patient or their SDM upon request to respond to questions or concerns.[17]

9. Dentists must ensure that the patient or SDM has time to consider the information provided, ask and receive answers to any follow-up questions or concerns, and reach a decision concerning consent.

10. As part of the consent discussion, dentists must ensure that information concerning fees are disclosed to the patient or their SDM before treatment is initiated (e.g., the expected cost of treatment, any anticipated additional costs

[11] For more information about "informed refusal", see the Consent to Treatment FAQs.

[12] s. 11(1) of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A.

[13] s. 10(1) and 11(1) of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A.

[14] Unless it is not reasonable to do so in the circumstances, the HCCA (s. 12) permits dentists to presume that consent to treatment includes:
a. consent to variations or adjustments in the treatment, if the nature, expected benefits, material risks and material side effects of the changed treatment are not significantly different; and consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks or material side effects of the treatment as a result of the change in the setting in which it is administered.

[15] s. 2 and 3 of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A.

[16] Dentists must use judgment when deciding which risks and side effects are to be disclosed. Based on relevant case law, dentists are advised to provide the patient with information that a reasonable person in the same circumstances would require to make a decision about the treatment. This would include disclosure of those risks and side effects that are common, even though not necessarily grave, and those that are rare, but particularly significant. For more information, see the Consent to Treatment FAQs.

[17] s. 11(2)(b) of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A.

that may arise once treatment is underway, and any relevant information related to insurance coverage).[18]

EXPRESS AND IMPLIED CONSENT

11. While consent can be either express or implied, dentists are advised to obtain express consent when the treatment:
   a. is likely to be more than mildly painful;
   b. carries appreciable risk;
   c. will result in loss or impairment of a bodily function;
   d. is a surgical procedure or an invasive investigative procedure; or
   e. will lead to significant changes in consciousness.

DETERMINING CAPACITY

In order to proceed with treatment, the individual giving or refusing consent (i.e., the patient or their SDM) must be 'capable' with respect to the treatment. Importantly, capacity is not static: a person may be capable with respect to some treatments and not others, they may be capable at one point in time and not another, and capacity can be present, fade, or return with the individual's mental well-being or clarity of thought. Where dentists are unsure about an individual's capacity, they are advised to seek guidance from RCDSO's Practice Advisory Service or the Consent and Capacity Board (CCB)[19].

Patient Capacity

12. Dentists must ensure that the patient giving or refusing consent is capable with respect to the treatment being proposed.[20] Dentists are entitled to presume capacity unless there are reasonable grounds to believe otherwise (e.g., something in the patient's history or behaviour raises questions about their capacity).

13. Because capacity is not static, dentists must continue to consider the patient's capacity at various points in time and in relation to the specific treatment being proposed or administered.

14. If a patient disagrees with a dentist's determination that they are incapable of consenting to treatment, the dentist must advise the patient of their right to apply to the CCB for a review of the finding.

15. If a patient disputes a dentist's determination that they are incapable of consenting to treatment, the dentist must not provide treatment until the matter can be resolved, or the CCB has rendered a decision. To facilitate a timely resolution, dentists are advised to recommend that the patient submit their formal disagreement to the CCB for review.

Substitute Decision-Makers (SDMs)

16. When a patient is incapable of giving or refusing consent to treatment, the dentist must ensure that consent is obtained from the highest-ranking person in the hierarchy of substitute decision-makers as set out in the HCCA, 1996 (see Appendix A).[21]

17. If the highest-ranking person in the hierarchy does not satisfy all of the requirements for substitute decision-making under the legislation,[22] the dentist must move to the next-highest-ranking person who meets the requirements.

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[18] This is a requirement of RCDSO to help ensure that patients are fully informed before making a treatment decision. This is not a requirement in legislation (e.g., the *HCCA, 1996*).

[19] The Consent and Capacity Board (CCB) is a quasi-judicial administrative tribunal which operates at arm's length from the Ministry of Health. The Board convenes hearings and makes decisions under six Acts, including the *Health Care Consent Act*. The Board aims to provide timely, fair and accessible adjudication of issues relating primarily to matters of consent, capacity, and civil detention: https://www.ccboard.on.ca/scripts/english/aboutus/index.asp

[20] The *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A describes the criteria that must be met in order for an individual to be capable of giving or refusing consent: first, the person must be able to understand the information that is relevant to making a decision, and second, the person must be able to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.

[21] s. 10(1) of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A

18. Dentists must ensure that SDMs understand and comply with the principles for giving or refusing consent as set out in the HCCA, 1996.[23]
   a. the SDM must give or withhold consent in accordance with the most recent and known wish expressed by the patient, while capable and at least 16 years old;
   b. if there is no known or applicable wish, the SDM must make a decision guided by the patient's best interests.[24]

19. If a patient disputes the involvement of an SDM, the dentist must advise the patient of their right to direct their concerns to the CCB for review.

Minors

In Ontario, there is no fixed age of capacity to consent to treatment. This means that 'minors' may have capacity to give or refuse consent to treatment. The considerations that will inform an assessment of capacity of a minor are the same as those that would inform the assessment of an adult patient (i.e., the patient able to understand the relevant information and the reasonably foreseeable consequences of a decision).

20. If a dentist determines that a minor is capable with respect to treatment, the dentist must obtain consent from the minor directly, even if the minor is accompanied by a parent or guardian.[25] However, dentists are reminded that no one under the age of 18 can enter into a legally binding contract, which means that a payment arrangement cannot be entered into with anyone under the age of 18.

DOCUMENTATION

21. Dentists must document information regarding patient consent and capacity, including details of the consent discussion, as set out below, and in-keeping with RCDSO's Dental Recordkeeping Guidelines.

22. In general, dentists are advised that the more complicated or risky the treatment is, the more specific and detailed their documentation should be. This also applies to treatment undertaken for strictly cosmetic or aesthetic reasons.

23. Dentists must use their professional judgment to determine what specific information to document in relation to the consent discussion, taking into consideration the circumstances of each interaction. In general, dentists are advised (but not required) to record the following:
   a. the date;
   b. the names of any individuals who participated in the consent discussion or their relationship to the patient (e.g., "mother" or "father");
   c. the specific potential risks and benefits that were communicated, including any risks associated with refusing, withholding, or withdrawing consent;
   d. any significant questions or concerns raised by the patient or SDM;
   e. any alternative treatments or options that were discussed, including no treatment;
   f. whether consent was given or refused, and by whom;
   g. what was consented to, if anything; and
   h. any discussions or agreements concerning the anticipated cost of treatment.

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[22] s. 2 of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A. Requirements include that the SDM:
   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 incapable person or giving or refusing consent on their behalf;
   d. is available; and
   e. is willing to assume the responsibility of giving or refusing consent.

[23] s. 21 of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A.

[24] If an SDM is not making decisions in accordance with the principles for substitute decision making set in the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A, dentists may bring a "Form G" application to the Consent and Capacity Board for review.

[25] For more information about obtaining consent from a minor, see the Consent to Treatment FAQs.

24. When there has been a determination of incapacity, dentists are advised to record:
   a. the information, circumstances, or reasoning that were the basis for the determination of incapacity;
   b. the name and the relationship of the person who has been identified as the patient's SDM; and
   c. whether the SDM has been given a power of attorney for personal care for the patient.

EMERGENCY TREATMENT

In limited circumstances, dentists may find themselves in emergency situations where it is not possible or in the patient's best interest to obtain consent prior to administering treatment. For instance, this could occur in situations where a patient is incapable of communicating their consent, and where administering immediate treatment would relieve severe suffering or reduce the risk of serious bodily harm. The HCCA, 1996 sets out specific requirements that healthcare providers must meet when providing emergency treatment.[26]

25. In emergencies, dentists must obtain consent from the patient or their SDM unless:
   a. the communication required in order for consent to be given or withheld cannot take place (e.g., because of a language barrier or disability, or because the SDM cannot be reached);
   b. steps that are reasonable in the circumstances have been taken to find a practical means of enabling communication, but none have been found;
   c. the delay required to find a practical means of enabling communication will prolong the suffering of the patient or put them at risk of serious bodily harm; and
   d. there is no reason to believe that the patient does not want the treatment.

26. Dentists must not provide treatment in emergencies if they have reasonable grounds to believe that the patient, while capable and at least 16 years of age, has expressed a wish applicable to the circumstances to refuse consent to the treatment.[27]

CONSENT FORMS

Consent forms can be a helpful way to reinforce information about the proposed treatment and support informed decision-making, however, dentists are reminded that a signed consent form is not consent itself. A consent form is only as useful as the consent discussion that accompanied it, and forms are not a substitute for the requirements set out in this Standard of Practice or the HCCA, 1996.[28]

27. Dentists must ensure that they fulfill all of the requirements for obtaining consent as set out in this Standard of Practice and the HCCA, 1996, regardless of whether they are using supporting documents (e.g., a consent form).

28. Dentists must ensure that consent forms that have been signed by the patient or their SDM are retained as part of the patient's record.

[26] s. 25 of The *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A.

[27] s. 26 of The *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A.

[28] For more information about Consent Forms (including a sample form), see the Consent to Treatment FAQs.

APPENDIX A: HIERARCHY OF SUBSTITUTE DECISION-MAKERS (SDMs)

If a person is incapable with respect to a treatment, consent may be given or refused on their behalf by a person described in one of the following paragraphs:[29]

1. The incapable person's guardian, if authorized to give or refuse consent to the treatment.
2. The incapable person's attorney for personal care, if authorized to give or refuse consent to the treatment.
3. The incapable person's representative appointed by the Consent and Capacity Board (CCB), if authorized to give or refuse consent to the treatment.
4. The incapable person's spouse or partner.
5. A child or parent of the incapable person, or a children's aid society or other person who is entitled to give or refuse consent to the treatment (this does not include a parent who has only a right of access).
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.

The SDM is the highest-ranking person set out in the above list who is also:

1. capable with respect to the treatment;
2. at least 16 years old, unless they are the incapable person's parent;
3. not prohibited by court order or separation agreement from having access to the incapable patient or giving or refusing consent on their behalf;
4. available; and
5. willing to assume the responsibility of giving or refusing consent.

[29] s. 20 (1) of The *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A.