

Index

Acute care medicine challenges, generally

- consent, role in decision-making, 7-9
- end of life, 11-13
- fiduciary duty of health care practitioners, 5-6
- generally, 1-3, 14
- health care spending, 2
- human dignity and substitute decision-making, 9-11
- personal values and religious beliefs, role of, 6-7
- purpose of acute care medicine, 3-4
- standard of care, 4-5, 6

Acute resuscitation committee (“ARC”), role of, 436

Advance care planning

- distinguished from level of care forms, 374-375
- end of life, and, 364-365
- generally, 8, 155, 157, 159, 183, 186, 189, 192, 205-207, 210, 219, 449, 476
- planning in other provinces, 187-188
- precision in, 335
- substitute decision-maker, and, 153, 156, 216-217

Advanced cardiac life support (“ACLS”), 369, 435, 436, 448, 479

Canadian Medical Association Code of Ethics

- Alberta, 263
- generally, 32, 234, 263, 264, 284
- Manitoba, 349
- Saskatchewan, 264

Capacity

- assessment in acutely deteriorating patients, 122-125
- best practices for health care practitioners, 131-133
- best practices for hospitals and health care facilities, 133
- clinical tools —
 - documentation of decision-making capacity, 134

Capacity — *continued*

- Consent and Capacity Board (CCB), 121-125, 132, 133, 139
- determination of capacity, 119-120
- documentation, 120-121
- generally, 115-118
- legal requirements, 118-119
- outside Ontario, 125-130
- practical questions and answers —
 - emergency situations, 134-137
 - non-emergency situations, 138-143
- provincial legislation concordance table, 144-149
- review of capacity decisions, 121-122
- where patient incapable, 121

Case studies

- emergency department —
 - elder abuse, 387-391
 - end of life, 373-384
 - gunshot / stabbing wounds, 408-416
 - sexual assault, 391-394
 - suicide attempts, 400-402
 - suspected crimes, 384-387
 - toxicology, 398-399
 - trauma bay, 402-408
 - violence towards staff, 394-398
- general internal medicine wards —
 - demands for Rx / do everything, 422-427
 - resuscitation —
 - offering / not offering, 416-422
 - refusal, 436-438
 - slow codes, 433-436
 - substitute decision-making standards and complaints, 427-432
- intensive care units —
 - cardiac arrest, withholding and withdrawing life support, 462-466
 - critical incident resulting in admission to ICU, 466-471
 - demands for treatment, to offer / not to offer, 454-462
 - resource allocation, 471-474
- surgical wards —
 - no CPR status and quality of care issues, 445-448
 - surgery —
 - complications / consent issues, 443-445
 - not offering / demands for, 438-443
 - treatment goals, 448-451

Case studies — *continued*surgical wards — *continued*

triage / resource allocation issues, 451-454

Charter of Rights and Freedoms

brain death, and, 350, 352-353

capacity and informed consent, and, 7-8

end-of-life care issues, and, 11

medical assistance in dying, and, 323, 356-357, 360, 361

Clinical tools

capacity —

documentation of decision-making capacity, 134

standard of care —

ITEST / ITREAT, 61

ITRREAAT, 60-61

substitute decision-making —

documenting conflict mediation meetings re substitute decisions,
199-200

documenting emergency treatment without consent, 197

documenting non-offer of CPR or other life-sustaining treatments,
198-199

documenting treatment decisions with SDMs, 197-198

College of Physicians and Surgeons, Ontario (“CPSO”) Policy Statements

“Consent to Treatment”, 72, 76, 78, 81, 90, 121

“Medical Assistance in Dying”, 359

“Planning For and Providing Quality End-of-Life Care”, 52-53, 101,
164-165, 347-349, 376-377**Concordance tables**

capacity, 144-149

informed consent, 111-113

privacy and confidentiality, 287-307

substitute decision-making, 221-230

Confidentiality. See Privacy and confidentiality**Consent, see also Informed consent, Consent and Capacity Board (“CCB”)**Consent and Capacity Board (“CCB”), review of capacity
determinations, 121-122

role in decision-making, 7-9

Consent — *continued*

where patient is incapable, 121

Consent and Capacity Board (“CCB”)

applications —

appointment or termination of representative, 181

determination of capacity, 182

override of expressed wishes, Form E, 179-180

review of applicability of wishes, Form D, 179

review of substitute decision-maker’s decision, Form G, 180-181

consent to withdraw treatment not obtained, where, 57

generally, 86-87, 121-125, 132, 133, 139, 329-330, 333-334, 350, 353, 372

Crimes, suspected, case study, 384-387**Critical incidents**

best practices in Canadian hospitals, 279-281

defined —

Hospital Management regulation under *Public Hospitals Act*, 283-284

Quality of Care Information Protection Act, 2016, 237-238

disclosure and reporting, 233, 283-285

documentation, 93, 285

generally, 238

quality of care information, 239

role of hospital administration, 286

“Critical interests” of person, 65, 73, 116**Disclosure of patient information - special reporting situations**

best practices when disclosing information to police, 261

disclosure authorized by warrant or law, 260

disclosure of patient information for use in research or case studies, 272-273

disclosure of patient information to lawyers, 268-269

disclosure of patient information to media, 269-272

disclosure of patient information to police, 259-260

disclosure related to risks of harm to others, 261

disclosure to health authorities, 260

other mandatory reporting —

child abuse or neglect, 262

communicable or reportable diseases, 266-267

controlled drugs and substances, 268

Disclosure of patient information – special reporting situations —
continued

- other mandatory reporting — *continued*
 - deaths, 265-266
 - incapacity, incompetence and sexual abuse, 265
 - reactions to immunizations, 267-268
 - sexual abuse of patient, 262-264
 - social media, 273-274

Elder abuse, case study, 387-391

Emergency department, case studies

- elder abuse, 387-391
- end of life, 373-384
- gunshot/stabbing wounds, 408-416
- sexual assault, 391-394
- suicide attempts, 400-402
- suspected crimes, 384-387
- toxicology, 398-399
- trauma bay, 402-408
- violence towards staff, 394-398

End-of-life care

- artificial nutrition and hydration, 330-335
- best interests, 325-328
- best practices for health care practitioners, 361-364
- best practices for hospitals and health care facilities, 364-365
- case study, 373-384
- Framework on Palliative Care in Canada Act*, 324
- generally, 319-324, 372
- informed consent, 324-325
- medically assisted death, 355-361
- pain and well-being considerations, 328-330
- palliative care, defined, 320
- “Planning For and Providing Quality End-of-Life Care”, CPSO
 - policy, 52-53, 347
- practical questions and answers —
 - emergency situations, 366-368
 - non-emergency situations, 368-372
- prior capable wishes, 325-326
- religious or cultural beliefs, 7
- withdrawal of life-sustaining treatments —
 - case law, 350-355

End-of-life care — *continued*withdrawal of life-sustaining treatments — *continued*

generally, 335-340

policies, 347-350

Rasouli (Litigation Guardian of) v. Sunnybrook Health Sciences Centre (S.C.C.), 341-346***Excellent Care for All Act, 2010***, 238**Fiduciary duty of health care practitioners**, 5-6**General internal medicine wards, case studies**

demands for Rx/do everything, 422-427

resuscitation —

offering/not offering, 416-422

refusal, 436-438

slow codes, 433-436

substitute decision-making standards and complaints, 427-432

Glossary of Abbreviations, 479-486**Gunshot/stabbing wounds, case study**, 408-416***Health Care Consent Act, 1996***

best interests, 176-177, 327

capacity determination, 118-120

Consent and Capacity Board applications, 179-182

consent not required in certain situations, 80-81

definitions —

community treatment plan, 78

course of treatment, 77

emergency, 80

plan of treatment, 77-78

treatment, 77

emergency treatment provisions, 70-71

health care decision-makers, 162-164, 165-166

incapacity, instructions about future care prevail after, 174, 326

informed consent provisions, 75-76, 80-81

substitute decision-makers, 166-167, 170-173

Hopp v. Lepp, 43, 74**Human dignity and substitute decision-making**, 9-11

Informed consent

- acute situations —
- “assent” in end-of-life care, 94-98
- best practices for health care practitioners —
 - generally, 98-99
 - Rasouli (Litigation Guardian of) v. Sunnybrook Health Sciences Centre (S.C.C.)*, 99-102
- best practices for hospitals and health care facilities —
 - generally, 102-103
 - intra and inter-facility documentation of resuscitation (code) status, 104
- communication of consent, 79
- documentation, 89-94
- emergency situations, consent not possible, 80-81
- explicit vs implicit, what is required, 77-79
- generally, 8, 69-74
- Hopp v. Lepp*, 43, 74
- legal definition, 74-76
- modified objective test, 19, 106
- outside Ontario, 81-86
- practical questions and answers —
 - documentation, 109-110
 - emergency situations, 105-106
 - non-emergency situations, 106-109
- provincial legislation concordance table, 111-113
- Reibl v. Hughes*, 43, 44, 74, 75, 106
- required level of detail, 86-88
- revisiting consent, 79
- right to refuse treatment vs right to mandate treatment, 72
- use of information brochures and pamphlets, 88-89

Intensive care units, case studies

- cardiac arrest, withholding and withdrawing life support, 462-466
- critical incident resulting in admission to ICU, 466-471
- demands for treatment, to offer/not to offer, 454-462
- resource allocation, 471-474

Intrusion upon seclusion, tort of

- application to health care sector, 253-254
- generally, 252-253
- privacy/confidentiality, failure to meet obligations, 274-279

ITEST/ITREAT, 60-61

ITRREAAT algorithm, 51, 60-61, 192, 321, 366, 378

Krever Report, 235

Level of care forms

distinguished from advance directives/advance care planning, 374-375
generally, 158-159, 367, 375-378

Medical assistance in dying (“MAiD”)

Charter of Rights and Freedoms, 323, 361
Criminal Code, 323, 359
defined, 358
eligibility, 358
Fourth Interim Report on Medical Assistance in Dying, 360-361
generally, 13, 323, 355-361, 401
grievous and irremediable condition, defined, 358
“Medical Assistance in Dying” CPSO policy statement, 359
Medical Assistance in Dying Act, 358-360
Regulations for the Monitoring of Medical Assistance in Dying, 360
safeguards, 359

Most responsible physician (“MRP”), 279, 385, 410, 420, 421, 429, 434, 435, 467, 468

Personal Health Information Protection Act, 2004 (“PHIPA”), 237, 244-245

Personal Information Protection and Electronic Documents Act (“PIPEDA”), 237

Privacy and confidentiality

best practices, critical incidents —
documentation: patient medical record vs critical incident report, 280-281
physicians and health care providers in hospitals, 279-280
failure to meet legal obligations —
intrusion upon seclusion, 274-279
violations of provincial privacy legislation, 274
generally, 231-234
history of patient privacy rights in Canada, 234-237
Canadian Medical Association Code of Ethics, 234
common law, 235
generally, 234

Privacy and confidentiality — *continued*

history of patient privacy rights in Canada — *continued*

Krever Report, 235

McInerney v. MacDonald, 235-236

Personal Information Protection and Electronic Documents Act (“PIPEDA”), 237

legal framework – Ontario —

consent to collection, use and disclosure of personal health information —

capacity to consent, 249

deceased patients, 252

disclosure of patient information by SDM to physician, 251

disclosure of patient information in health care facility, 251-252

documentation and implementation of consent, 250-251

need for patient or SDM consent, 245-249

generally, 237

intrusion upon seclusion —

application to health care sector, 253-254

generally, 252-253

Personal Health Information Protection Act, 2004, 244-245

Quality of Care Information Protection Act, 2016, 237-244

legal framework – outside Ontario, 254-259

practical questions and answers, 281-286

provincial Coroners Acts and Fatality Reporting Acts —

Coroners Act (B.C.), 308-309

Coroners Act (N.B.), 316

Coroners Act (P.E.I.), 317

Coroners Act (Que.), 313

Fatality Inquiries Act (Alta.), 309-310

Fatalities Investigations Act (Nfld. & Lab.), 314-316

Fatality Investigations Act (N.S.), 313-314

The Coroners Act (Sask.), 311

The Fatality Inquiries Act (Man.), 312-313

provincial legislation concordance table, 287-307

special reporting situations —

best practices when disclosing information to police, 261

disclosure authorized by warrant or law, 260

disclosure of patient information for use in research or case studies, 272-273

disclosure of patient information to lawyers, 268-269

disclosure of patient information to media, 269-272

disclosure of patient information to police, 259-260

disclosure related to risks of harm to others, 261

Privacy and confidentiality — *continued*special reporting situations — *continued*

disclosure to health authorities, 260

other mandatory reporting —

child abuse or neglect, 262

communicable or reportable diseases, 266-267

controlled drugs and substances, 268

deaths, 265-266

incapacity, incompetence and sexual abuse, 265

reactions to immunizations, 267-268

sexual abuse of patient, 262-264

social media, 273-274

suspicions of crime, 260-261

Provincial Coroners Acts and Fatality Reporting Acts*Coroners Act* (B.C.), 308-309*Coroners Act* (N.B.), 316*Coroners Act* (P.E.I.), 317*Coroners Act* (Que.), 313*Coroners Act, The* (Sask.), 311*Fatality Inquiries Act* (Alta.), 309-310*Fatalities Investigations Act* (Nfld. & Lab.), 314-316*Fatality Investigations Act* (N.S.), 313-314*Fatality Inquiries Act, The* (Man.), 312-313**Provincial legislation, concordance tables**

capacity, 144-149

informed consent, 111-113

privacy and confidentiality, 287-307

substitute decision-making, 221-230

Quality improvement plans ("QIP"), 238**Quality of Care Committees ("QOC")**

disclosure of information, 238, 239, 241, 242

role of, 240

use of information in legal proceedings, 243-244

Quality of Care Information Protection Act, 2016

generally, 237-239

nature of information privilege, 242-243

offences and liability for breaches, 244

Quality of Care Committee, role of, 240

use of quality of care information in legal proceedings, 243-244

Quality of Care Information Protection Act, 2016 — *continued*

what information is privileged, 240-241

Rasouli (Litigation Guardian of) v. Sunnybrook Health Sciences Centre (S.C.C.)

consent, 99-102, 325, 342-343

Court of Appeal decision, 340

“critical interests”, 65, 73, 116

medical benefit vs health-related purpose, 56, 341-342

steps for end-of-life conflict resolution, 371-372

treatment, defined, 78

withdrawal of life-saving treatment, 48, 55, 64-65, 73, 76, 116, 335

Reibl v. Hughes, 43, 44, 74, 75, 106**Religious beliefs**

end-of-life care, 321, 337-338, 341, 352-355, 365, 372, 380, 382, 383, 424, 425

generally, 6-7, 84-85, 142, 206, 209, 458, 459-460

Research ethics boards (“REB”), 232, 272-273**Resuscitation, case studies**

offering/not offering, 416-422

refusal, 436-438

Return of spontaneous circulation (“ROSC”), 64, 408, 434, 462, 467, 485**Right of self-determination**, 3, 4, 8, 9, 10, 11, 44, 72, 88, 115, 116, 122, 322, 324, 477**Right to refuse treatment vs right to mandate treatment**, 72**SDM. See substitute decision-making****Sexual assault, case study**, 391-394**Slow codes, case study**, 433-436**Standard of care**

best practices for acute health care practitioners —
cardiopulmonary resuscitation and life-support, 52-57

generally, 49-51

withholding treatments, 51

Standard of care — *continued*

- best practices for hospitals and health care facilities, 57-59
- clinical tools —
 - ITEST / ITREAT, 61
 - ITRREAAT, 60-61
- generally, 4-5, 6, 15-17
- Hopp v. Lepp*, 43
- medical profession, and, 17-21
- practical questions and answers, 62-67
- Reibl v. Hughes*, 43, 44
- relevant principles, 22-35
 - cases decided on own facts, 22
 - changes in techniques, knowledge and technology, 23-24
 - cost considerations irrelevant, 27-28
 - courts rarely second-guess established medical practice, 22-23
 - divergences in medical opinion or practice, 24-25
 - epidemics, pandemics and mass casualty situations, 31-35
 - higher risk, higher standard, 25-26
 - inexperienced health care practitioners, 28-31
 - specialists, 28-31
- what is required —
 - duty to attend, 36-37
 - duty to co-ordinate with other health care practitioners and to supervise, 48-49
 - duty to diagnose, 37-40
 - duty to inform and disclose, 43-44
 - duty to keep full records, 40-41
 - duty to refer, 41-43
 - duty to treat and provide adequate aftercare, 45-46

Substitute decision-making

- advance care plans, 157
- best practices for documentation, 196
- best practices for health care practitioners in emergency situations, 188-191
- best practices for health care practitioners in non-emergency situations —
 - availability of SDM, 193-194
 - conflicts among SDMs, 193
 - conflicts between physicians and SDMs, 194
 - educating SDMs, 191
 - initiating treatment, 192
 - insistence on treatment, 192

Substitute decision-making — *continued*

- best practices for health care practitioners in non-emergency situations — *continued*
 - verbal designation of SDM, 194
- best practices for hospitals and health care facilities —
 - documentation of decision-making, policies for, 195-196
 - educating SDMs, 195
- case study, standards and complaints, 427-432
- clinical tools —
 - documenting conflict mediation meetings re substitute decisions, 199-200
 - documenting emergency treatment without consent, 197
 - documenting non-offer of CPR or other life-sustaining treatments, 198-199
 - documenting treatment decisions with SDMs, 197-198
- conflict among SDMs, 156
- conflicts at end of life, 160-161
- Consent and Capacity Board applications
 - appointment or termination of representative, 181
 - determination of capacity, 182
 - override of expressed wishes, Form E, 179-180
 - review of applicability of wishes, Form D, 179
 - review of substitute decision-maker's decision, Form G , 180-181
- generally, 9-11, 151-153
- guiding principles —
 - best interests, 176-178
 - generally, 173-174
 - wishes, 174-175
- human dignity and, 9-11
- information sharing by SDMs, 159
- legal framework – Ontario —
 - decision-makers —
 - health care practitioner in certain emergencies, 162-165
 - health care practitioner to determine if emergency exists, 165-166
 - patient with capacity, 162
 - substitute decision-makers, 166-173
 - generally, 161-162
- legal framework – outside Ontario —
 - advance care planning, 187-188
 - substitute consent and urgent care, 185-187
 - substitute consent legislation and principles, 182-185
- legal responsibilities, adherence to, 159-160
- level of care forms, 158-159

Substitute decision-making — *continued*

- practical questions and answers —
 - identifying and choosing SDM in emergency situation, 200-207
 - identifying and choosing SDM in non-emergency situation, 207-216
 - working with SDM, 216-220
- provincial legislation concordance table, 221-230
- standards and complaints, case study, 427-432
- understanding the role, 153-154
- willingness to act, 154-156

Substitute Decisions Act, 1992, 161, 167, 179

Suicide attempts, case study, 400-402

Surgical wards, case studies

- no CPR status and quality of care issues, 445-448
- surgery —
 - complications / consent issues, 443-445
 - not offering / demands for, 438-443
- treatment goals, 448-451
- triage/resource allocation issues, 451-454

Suspected crimes, case study, 384-387

Toxicology, case study, 398-399

Trauma bay, case study, 402-408

Violence towards staff, case study, 394-398

Withdrawal of life-sustaining treatments

- case law, 350-355
- generally, 335-340
- policies, 347-350
- Rasouli (Litigation Guardian of) v. Sunnybrook Health Sciences Centre* (S.C.C.), 48, 55, 64-65, 73, 76, 116, 335, 341-346

World Health Organization (“WHO”)

- elder abuse, defined, 388
- palliative care, defined, 320