

Consent for Health Care

1. Introduction

1.1. Description

BC law requires [Health Care Providers](#) to obtain prior consent for [Health Care](#) from the patient, client, or resident ([Client](#)) or a [Substitute Decision Maker](#) (SDM) with authority to make that decision, subject to exceptions set out in law. This policy explains the legal and operational requirements related to consent for [Adults](#) and [Minors](#).

1.2. Scope

This policy applies to:

- All Vancouver Coastal Health Authority (VCH) and Providence Health Care (PHC) [Staff](#), including [Medical Staff](#) (Staff) and VCH [Credentialed Medical Providers](#) (hereafter referred to collectively as “Staff”);
- All Health Care, except for specific exceptions set out in this policy; and
- All programs, units, and departments, including home and community care.

Consent to care facility admission follows a separate legislative process explained in the [Care Facility Admission Consent](#) policy.

This policy refers to SDMs, including a [Temporary Substitute Decision Maker](#) (TSDM) chosen under the *Health Care (Consent) and Care Facility (Admission) Act*. [Appendix A](#) explains the different kinds of SDMs, including their legal rights and responsibilities.

1.3. Exceptions

This policy does not apply to consent to photographs, video or audio recordings, social media, or other media by Clients or Staff. Client consent does not permit Staff to take or publish photographs of Clients. Staff must follow PHC and VCH policies and procedures with respect to consent to photographs, recordings, social media, and other media. See [Section 5](#) of this policy for details.

2. Policy

2.1. General Principles

VCH and PHC promote:

- [Culturally Safe](#) environments and respect for Indigenous people when seeking consent to Health Care; and
- Interactions with Clients that are [trauma and violence informed](#).

2.2. General Consent Requirements

Staff must:

- Respect Client autonomy, including their right to make informed Health Care decisions, based on any grounds, such as moral or religious grounds;
- Provide Clients and their SDMs with timely and relevant information upon which to base their Health Care decisions;
- Communicate in ways that are sensitive to the unique abilities of each Client in order to support their ability to understand information;
- Obtain prior consent for Health Care, subject to exceptions set out in [Section 2.12](#) of this policy;
- Respect a capable Client's right to revoke consent and be sensitive to indicators that a Client no longer consents to the Health Care;
- Ensure that consent is appropriately documented as per [Section 2.13](#) of the policy; and
- Ensure the Client or their SDM has access to language interpretation if they require it to communicate with Staff. Free services include [PHSA Provincial Language Services](#) and Virtual Interpretation ([VCH](#) and [PHC](#) staff links).

2.3. Staff Support and Guidance Regarding Consent

Consent issues can be challenging. For support and guidance, Staff may contact, [VCH](#) or [PHC](#) Ethics Services, or the Operations Leader or Social Worker.

2.4. Capability to Consent to Health Care

All Adults are presumed to be capable of giving, refusing, and revoking consent. If a Client's capability is in question, Staff must assess them to determine whether they understand:

- the information relevant to making a particular Health Care decision; and
- that the information applies to them and their situation.

The assessment must be timely because incapability is not a permanent state. Capability can vary across time and depend on a Client's mental or physical well-being. Clients may be capable of making some decisions, and not others.

Staff must support and respect Client capability by:

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- Avoiding assumptions about capability based on a Client's diagnosis;
- Abiding by a capable Client's decision to accept or refuse Health Care even if on a previous day a SDM made a different decision when the Client was not capable; and
- Allowing family and friends to participate in Health Care decision making if they can support a Client to understand information or communicate their wishes, **and** the Client wants them to participate.

2.5. How Consent is Given

Staff must be attentive to a Client's unique ways of communicating and allow a Client to give, refuse, or revoke consent in any manner that is permitted by law and meets the requirements of this policy. Clients may express their consent:

- orally;
- in writing;
- with the assistance of an interpreter; and/or
- with actions, symbols, shapes, or marks, particularly if they have a disability that impacts their ability to communicate.

2.6. The Requirements of Informed Consent

Consent for Health Care must:

- be specific to the proposed Health Care;
- be given voluntarily, i.e., not due to physical or emotional coercion; and
- not be obtained through fraud or misrepresentation.

Consent for Health Care must be informed. Staff must provide the Client the information they require to understand the proposed Health Care, including information about:

- The condition for which the Health Care is proposed;
- The nature of the proposed Health Care;
- The material risks and benefits of the proposed Health Care; and
- The material risks and benefits of alternative courses of Health Care, including the option of no Health Care.

Staff must give the Client the opportunity to ask questions about the proposed Health Care and provide answers.

If a Client is incapable, they must still be included in consent discussions. SDMs have a legal duty to consult with Clients about their wishes.

2.7. Consent for Minors

Capability to consent depends on the ability to understand information, not chronological age. With the exception of requests for Medical Assistance in Dying (MAiD), a Minor is capable of making their own Health Care decision if:

- The Minor understands the nature and consequences and the reasonably foreseeable benefits and risks of the Health Care; and
- Staff conclude that the proposed Health Care is in the Minor's best interests.

A Minor may be deemed capable to make certain decisions. A Minor who is able to make a Health Care decision is called a [Mature Minor](#) in relation to that decision, and may give consent, regardless of whether they are accompanied by a parent or [Legal Guardian](#). A parent or Legal Guardian gives consent if a Minor is not capable.

2.7.1. Duty to Report Revocation or Refusal for Minors

If a Minor revokes or refuses consent to Health Care that meets the standard of [Necessary Care](#), Staff must contact the parent or Legal Guardian, or notify the Ministry of Child and Family Development (MCFD) or the appropriate Indigenous Child and Family Services Agency if no parent or Legal Guardian is available or appropriate in the circumstances.

Parents and Legal Guardians must act in the best interests of Minors. If a parent or Legal Guardian revokes or refuses consent to Health Care that meets the standard of Necessary Care, Staff must notify MCFD or the appropriate Indigenous Child and Family Services Agency.

Staff must consult team members before contacting MCFD.

2.8. Consent to Research

Staff must obtain consent for medical research from a person with authority to give that consent:

- The Client consents if they are capable of making that decision.
- The Client may give consent in advance through a valid [Advance Directive](#).
- A [Representative](#) or [Committee of the Person](#) may consent if they have that authority and the program has been approved by a Research Ethics Committee or Board listed in the Health Care Consent Regulation (REB).
- A TSDM may consent if the medical research program has been approved by a REB.

2.9. Scope of Consent

Consent to Health Care applies only to the specific Health Care to which a Client has consented, including a course of treatment. If the proposed Health Care changes, Staff must obtain consent for the proposed change of care.

VCH and PHC facilities are teaching facilities. However, where possible, Staff must respect a Client's wish that students not be involved in providing their Health Care.

2.9.1. Additional or Alternative Health Care that is Medically Necessary

Staff may provide additional or alternative Health Care without further consent if [Section 2.12.1](#) of this policy applies, or the following four criteria apply:

1. The Health Care that was originally consented to is in progress; and
2. The Client receiving the Health Care is unconscious or semi-conscious; and
3. It is medically necessary to provide additional or alternative Health Care to deal with conditions not foreseen when the consent was originally given; and
4. There is no Advance Directive that conflicts with providing additional or alternative Health Care.

2.10. Duration of Consent

Staff must obtain consent again if there is a change in their knowledge about the condition or the treatment options available to the Client.

If a previously incapable Client becomes capable, they may make their own decision about the proposed Health Care unless they have a Committee of Person. Staff must observe for changes in capability and ensure that they only obtain consent from a SDM if a Client is incapable.

Consent from a TSDM must be obtained no more than 21 days before the Health Care begins.

Consent for School-Based Immunization is generally effective for the length of the series consented to, unless consent is revoked. For more information contact Public Health and see the [Communicable Disease Control Manual](#) (Appendix A).

2.11. Advance Directives

If a Client is incapable of making a particular Health Care decision, Staff must comply with an [Advance Directive](#) a Client created when they were capable which addresses the proposed Health Care, and a TSDM does not have authority to give or refuse consent.

An Advance Directive must be:

- in writing;

- signed by the Client;
- witnessed, and dated;
- voluntary; and
- made without fraud or misrepresentation;

Staff should not follow an Advance Directive if it:

- conflicts with the Client's known values, wishes, or beliefs; or
- was made prior to changes in medical knowledge or technology that might benefit the Client (unless the Advance Directive stipulates that it will apply regardless).

If Staff become aware that a Client is receiving Health Care they refused in an Advance Directive, they must withdraw this Health Care (unless the previous paragraph applies).

Advance Directives are different from an advance care plan. Learn more about advance care planning: [VCH PHC](#).

2.12. Informed Consent Exceptions

Staff must only provide Health Care without obtaining informed consent in the following situations or if [Section 2.9.1](#) of this policy applies:

2.12.1. Emergency or Urgent Care

Staff must only provide [Emergency or Urgent Care](#) without consent as per Section 12 of the *Health Care (Consent) and Care Facility (Admission) Act* if, in the opinion of one Health Care Provider (or two when possible), the Client:

1. Is incapable of making the consent decision; and
2. Does not have a relevant Advance Directive; and
3. Does not have a known and available SDM that Staff can contact for consent, or parent or Legal Guardian if the Client is a Minor; and
4. Has not refused to consent to the specific Health Care required via a previously capable expression or instruction; and
5. Requires this care without delay to preserve their life, to prevent serious mental or physical harm to them, or to alleviate severe pain.

A Client can only be [Restrained](#) without consent under Section 12 if the 5 criteria above apply.

Section 12 can only be used to involuntarily admit or to refuse to discharge a Client if the admission or discharge is related to providing Emergency or Urgent Care and the 5 criteria above apply.

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Staff must obtain consent to continue to provide the Emergency or Urgent Care or to provide other forms of Health Care if the Client becomes capable, the Emergency or Urgent Care need is addressed, or a SDM becomes available.

2.12.2. Preliminary examination, treatment, or diagnosis

Staff must only undertake triage or another kind of preliminary examination, treatment, or diagnosis of a Client without obtaining informed consent if:

- The Client indicates that they want to be provided with Health Care; or
- The Client does not express a preference, and the Client's spouse, relative, or friend indicates that they want preliminary examination, treatment or diagnosis to occur.

Staff must introduce and explain the preliminary examination, treatment, or diagnosis prior to undertaking it, and answer any questions about the care.

2.12.3. Involuntary Psychiatric Treatment

Clients may be assessed and provided involuntary psychiatric treatment under the *Mental Health Act* via the deemed consent provisions, as determined by the treating physician and Director of a Designated Facility. For further information, refer to the [Procedure on Protecting People's Rights under BC's Mental Health Act: Legal Form Requirements for Involuntary Admission](#).

Staff must follow this policy on Consent to Health Care with respect to all other Health Care provided to Clients who have been admitted for involuntary psychiatric treatment.

2.12.4. Drawing Blood Samples for Legal (Non-Medical) Purposes

Law enforcement who suspect that an individual has been operating a motor vehicle while impaired by alcohol or other substances have the right to demand a blood sample. Consent is required prior to blood collection unless law enforcement presents a warrant. For further information, refer to VCH policy [Release of Blood Draw from Patients to Police](#).

2.13. Documentation

2.13.1. Consent Discussions

Staff must record consent discussions and decisions in the Client's health record.

Regulated Health Care Providers must follow college regulations and standards regarding documentation of consent discussions and decisions.

In some situations, VCH and PHC require Staff to document consent using forms. Staff must ensure forms do not create Health Care barriers for people with disabilities.

2.13.2. Documentation on the VCH and PHC Health Care Consent Form

The VCH and PHC Health Care Consent form (Consent Form) must be completed and added to the Client's health record in the following situations (unless the form is not reasonably accessible):

- Administration within hospital of fractionated or non-fractionated blood products;
- Emergency or Urgent Care provided without consent; or
- As directed by program leadership.

All relevant portions of the forms must be completed. Any alterations to the form must be:

- Initialed by the Client or a person authorized to sign on their behalf; and
- Witnessed by the [Most Responsible Provider](#) (MRP) or [Most Responsible Clinician](#) (MRC).

If the Health Care is to be performed under the auspices of VCH or PHC but consent is obtained in a Health Care Provider's private office, the Consent Form must be completed in the Health Care Provider's office and sent to the appropriate department for inclusion on the Client's health record.

A sample of the Consent Form is included as [Appendix B](#). The current version of the form is available on FormFast.

2.13.3. Agreement to Ongoing Use of a Chemical Restraint in a Care Facility

Medication use for the purposes of Restraint in a Care Facility is governed by both the *Health Care (Consent) and Care Facility (Admission) Act* and the *Residential Care Regulation*. Staff must obtain agreement in writing by the person with authority to consent to Health Care if a chemical restraint is used for longer than 24 hours. For more on this topic consult the Guideline, [Least Restraint: Guideline for Maximizing Independence \(in Residential Care\)](#).

2.13.4. Notice of Incapability and Substitute Consent (Major Health Care)

Staff who propose Health Care and determine a Client is Incapable must provide notice to the Incapable Client identifying who the TDSM is and what Health Care has been proposed and consented to by the TDSM. Use of Health Care Consent Regulation Form 1: Notice of Incapability and Substitute Consent (Major Health Care) is optional; alternate methods of providing this information may be used.

2.14. Adults in Need of Protection

2.14.1. Duty to Respond under the *Adult Guardianship Act* Part 3

Staff who suspect that consent or refusal of Health Care by a vulnerable Adult or the SDM constitutes abuse, neglect, or self-neglect must report as per the VCH [Adult Protection: Abuse, Neglect, or Self-Neglect of Vulnerable Adults](#) policy or the PHC [Screening Patients and Residents for Abuse](#) policy and the [Adult Protection: Duty to Report](#) Guideline.

2.14.2. Substitute Decision Makers not Fulfilling their Duties

TSDMs must:

- Consult a Client about their wishes (to the greatest extent possible); and
- Comply with any instructions or wishes a Client expressed while still capable.

TSDMs must consider a Client's best interests if the Client's wishes are unknown.

If the SDM is a [TSDM](#), and they are not complying with their [duties](#), the MRP or MRC may appoint the next person in the TSDM hierarchy as set out in [Appendix A](#).

3. Responsibilities

3.1. Most Responsible Provider and Most Responsible Clinician

The MRP or MRC must:

- Obtain consent;
- Document the consent decision; and
- Complete the necessary documentation for the course of treatment.

If the Client is determined to be incapable of consenting to the proposed Health Care, the MRP or MRC must make reasonable efforts to find out if there is a Committee of Person or Representative with authority to make the Health Care decision. If not, the MRP or MRC appoints an appropriate TSDM.

If a SDM is to give consent, the MRP or MRC must:

- Obtain relevant documentation of authority, such as the court order appointing Committee of Person or the Representation Agreement;
- Review the document to ensure the proposed Health Care is within the SDM's scope of authority; and

- Add a copy of this documentation to the Client's health record.

If a Minor is determined to be incapable, the MRP or MRC must contact the parent or Legal Guardian or notify MCFD or the appropriate Indigenous Child and Family Services Agency if no parent or Legal Guardian is available.

3.2. Other Staff

Staff must obtain prior consent for all the Health Care they provide, subject to exceptions discussed in this policy.

Staff must advise the MRP or MRC of any concerns that arise with respect to consent.

4. Compliance

Failure to comply with the terms of this policy is a serious infringement on the rights of Clients and may result in disciplinary action, up to and including termination of employment, services, or privileges, and/or legal consequences. Lack of compliance may also result in a complaint to the Staff's college or other Health Care regulator.

5. Supporting Documents and References

5.1. Related Policies

PHC

- [Advance Care Planning/Serious Illness Conversations](#)
- [Indigenous Cultural Safety](#)
- [Screening Patients and Residents for Abuse](#)
- [Information Privacy and Confidentiality](#)
- [Recording \(Photography, Video Recording and Audio Recording\) by Patients and Visitors](#)

VCH

- [Advance Care Planning: Development and Management](#)
- [Adult Protection: Abuse, Neglect, or Self-Neglect of Vulnerable Adults](#)
- [Indigenous Cultural Safety](#)
- [Release of Blood Draw from Patients to Police](#)
- [Information, Privacy and Confidentiality](#)

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- [Recording \(Photography, Video Recording and Audio Recording\) by Clients and Visitors](#)
- [Communications \(Websites, Social Media\) Branding, and Media](#)

VCH + PHC

- [Care Facility Admission Consent](#)

5.2. Guidelines, Procedures and Forms

PHC

- [Adult Protection: Duty to Report Guideline](#)
- [Photography / Media Consent and Release Form](#) [not available on SHOP]

VCH

- [VCH Duty to Report: A Supportive and Collaborative Approach to Child Abuse and Neglect Reporting](#)
- [Least Restraint: Guide for Maximizing Independence \(in Residential Care\)](#)
- [Trauma Informed Practice](#)

VCH + PHC

- [Protecting People's Rights under BC's Mental Health Act: Legal Form Requirements for Involuntary Admissions](#)
- [Notice of Incapability and Substitute Consent \(Major Health Care\) \(Form\)](#)
- [Governing Law and Jurisdiction Agreement](#)
- [Capability and Consent Tool BC Edition](#)
- Ministry of Health, BC, [Health Care Providers' Guide to Consent to Health care](#) (2011)
- [Involuntary Admissions under British Columbia's Mental Health Act \(MHA\) — Mandatory Form Completion](#)
- [Adult Protection: Duty to Report Guideline](#)
- [Social Media, Photography, Video, Audio-Recordings: Patients and Visitors in Imaging](#)

5.3. Other Resources

- College of Physicians and Surgeons of BC, [Practice Standard: Consent to Treatment](#)

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5.4. Keywords

Advance directive, blood sample, committee of person, consent, consent to health care, emergency care, health care consent, human rights, informed consent, medication, minor, necessary care, preliminary examination, representative, research, restraint, SDM, substitute decision maker, temporary substitute decision maker, TSDM, urgent care.

6. Definitions

“Adult” means any individual nineteen years of age or older who is receiving care from any VCH or PHC facility, program, or service.

“Advance Directive” refers to a legal document created pursuant to the *Health Care (Consent) and Care Facility (Admission Act)* where an Adult sets out their decisions regarding Health Care.

“Client” refers to any Adult or Minor who is receiving Health Care in VCH or PHC on an inpatient or outpatient basis, and includes any clients of community based programs and residents in Care Facilities.

“Committee of Person” refers to an individual appointed by a court to manage the personal and health affairs of an incapable Adult, pursuant to the *Patients Property Act*. See [Appendix A](#) for more information on Committees of Person.

“Credentialed Medical Provider” means a physician, nurse practitioner, midwife, or dentist who is credentialed with VCH to practice in a VCH community program or facility and provides clinical services in a VCH community program or facility pursuant to a contract or service agreement.

A **“Culturally Safe”** environment is physically, socially, emotionally, and spiritually safe, and is an outcome of cultural competency, defined and experienced by Indigenous Clients who receive the service. Cultural safety is based on understanding the power differentials and potential discriminations inherent in the health service delivery system.

“Designated Facility” means a provincial mental health facility, psychiatric unit, or observation unit; refers to specific hospitals or other facilities where a person may be admitted under authority of the *Mental Health Act*.

“Emergency or Urgent Care” means Health Care that is necessary and must be provided without delay in order to preserve the Client’s life, to prevent serious mental or physical harm, or to alleviate severe pain.

“Health Care” means anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic, or other purpose related to health, and includes:

- A series or sequence of similar treatments or care administered to a Client over a period of time for a particular health problem;
- A plan for care that:

- Is developed by one or more Health Care Providers;
- Deals with one or more of the health problems that a Client has and may deal with one or more of the health problems that a Client is likely to have in the future given the Client's current health condition; and
- Expires no later than 12 months from the date of consent; and
- Participation in a medical research program approved by an ethics committee designated by regulation.

"Health Care Provider" means a person, or a person in a prescribed class of persons, who, under a prescribed Act, is licensed, certified or registered in BC to provide Health Care.

"Legal Guardian" means a person who has been appointed as a Minor's guardian pursuant to the *Family Law Act*, or a Director or caregiver appointed under the *Child, Family, and Community Services Act*, who has the authority to consent to Health Care decisions on behalf of a Minor.

"Major Health Care" means major surgery, any treatment involving a general anesthesia, major diagnostic or investigative procedures, or any health care designated by law as Major Health Care, including radiation therapy, intravenous chemotherapy, kidney dialysis, electroconvulsive therapy, and laser surgery.

"Mature Minor" means any Minor who has been assessed as meeting the requirements of section 17 of the *Infants Act*, that is, they understand the nature and consequences and any foreseeable benefits or risks associated with proposed Health Care that the Health Care Provider has determined is in the Minor's best interest.

"Medical Staff" means privileged, employed, or contracted medical providers and medical leaders working at VCH or PHC or providing health care services through VCH or PHC, including physicians, midwives, nurse practitioners, dentists, and fellows. For clarity, this includes medical providers working both in hospital and community sites.

"Minor" means a person under nineteen (19) years of age.

"Most Responsible Clinician (MRC)" means the Staff accountable to coordinate/oversee the care of the Client in a community setting.

"Most Responsible Provider (MRP)" means the Staff accountable to coordinate/oversee the care of the Client for a specified procedure or course of treatment. The MRP is usually the attending physician or nurse practitioner.

"Necessary Care" is care which, in the opinion of two physicians / nurse practitioners, is necessary to preserve the Minor's life or to prevent permanent impairment of the Minor's health.

"Representative" is an individual appointed via a Representation Agreement to make Health Care and/or personal care decisions on behalf of another Adult if that Adult becomes incapable, or to help the Adult make decisions. Please see [Appendix A](#) for more on Representatives.

“**Restraint**” means any chemical, electronic, mechanical, physical, environmental, or other means of controlling or restricting a person in care's freedom of movement, including placement in a secure room.

“**Representation Agreement**” is a legal document that appoints a SDM or a decision making supporter chosen voluntarily by an Adult.

“**Staff**” means all employees (including management and leadership), Medical Staff, VCH Credentialed Medical Providers, resident doctors, fellows, trainees, students, volunteers, contractors, and other services providers engaged by VCH or PHC.

“**Substitute Decision Maker (SDM)**” refers to an individual authorized to make Health Care, personal care, or other type of decisions on behalf of an Adult. The hierarchy of Health Care SDMs is, in descending order:

1. A Committee of Person appointed by the court pursuant to the *Patients Property Act*;
2. An individual appointed as a Representative by an Adult via a Representation Agreement;
3. A Temporary Substitute Decision Maker (TSDM) chosen in accordance with section 16 of the *Health Care (Consent) and Care Facility (Admissions) Act*.

See [Appendix A](#) for further information about SDMs.

“**Temporary Substitute Decision Maker (TSDM)**” refers to the decision maker chosen by Staff to make a Health Care decision for a Client if they are not capable, do not have a relevant Advance Directive, and do not have a Representative or Committee of Person with relevant authority.

7. References

- [Adult Guardianship Act](#), RSBC 1996, c 6
- [Child, Family and Community Service Act](#), RSBC 1996, c 46
- [Health Care \(Consent\) and Care Facility \(Admission\) Act](#), RSBC 1996, c 181
- [Health Care Consent Regulation](#), BC Reg 20/2000
- [Infants Act](#), RSBC 1996, c 223
- [Mental Health Act](#), RSBC 1996, c 288
- [Patients Property Act](#), RSBC 1996, c 349
- [Representation Agreement Act](#), RSBC 1996, c 405
- [Residential Care Regulation](#), BC Reg 96/2009

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8. Appendices

- [Appendix A: Substitute Decision Makers](#)
- [Appendix B: Regional Consent Form for VCH and PHC](#)

Appendix A: Substitute Decision Makers

This Appendix does not apply to Minors. Refer to [section 2.7](#) of the Consent to Health Care Policy for information on consent for Minors.

If a Client is incapable of making a Health Care decision, and does not have a valid Advance Directive that addresses the proposed Health Care, Staff must obtain substitute consent from a party with authority to make that decision. This person is referred to as a Substitute Decision Maker (SDM).

8.1. Substitute Decision Makers and Invalid Advance Directives

If the Advance Directive is not valid due to a technical failure in signatures, it must be treated as a previously expressed wish that the SDM must consider when exercising their duties.

8.2. Information Rights of Substitute Decision Makers

SDMs have the right to receive all the same information that the Client would receive in order to make an informed consent decision.

8.3. Hierarchy of Types of Substitute Decision Maker

The [Health Care \(Consent\) and Care Facility \(Admission\) Act](#) sets out a hierarchy of SDMs. The hierarchy is:

- A court-appointed Committee of Person, pursuant to the [Patients Property Act](#);
- A Representative appointed by the Client in a validly executed Representation Agreement;
- A Temporary Substitute Decision Maker (TSDM), chosen by the Health Care Provider in accordance with the *Health Care (Consent) and Care Facility (Admission)*.

Attorneys appointed under a power of attorney do not have authority to make Health Care decisions in BC. A will also does not provide authority to make Health Care decisions.

8.4. Committee of Person

Under the *Patients Property Act*, the Supreme Court of British Columbia may appoint an individual to take over responsibility for an incapable Client's personal care and Health Care. This person is a Committee of Person. Once appointed, the Committee of Person is responsible for making all decisions regarding personal care and Health Care.

The similarly named Committee of Estate may be appointed by the court to manage an Adult's financial and legal affairs. A Committee of Estate is not entitled to make personal care or Health Care decisions.

The MRP or MRC must always ask to see a record of the appointment in order to ensure the Committee is a Committee of Person. The MRP or MRC must enter this documentation into the Client's health record.

8.5. Representative

A Client may have planned for future incapability by appointing a person to serve as their Representative via a Representation Agreement made under the [Representation Agreement Act](#). A Client may only create a Representation Agreement when they have the capability to do so.

Representatives must carry out their duties under section 16 of the *Representation Agreement Act*.

The MRP or MRC must obtain copies of the Representation Agreement and review it to ensure the proposed Health Care is within scope of the Representation Agreement. A copy of the Representation Agreement must be added to the Client's health record.

The *Representation Agreement Act* allows for two types of Representatives:

8.5.1. Section 7 Representative

Section 7 Representation Agreements, or Standard Representation Agreements, permit a Representative to make decisions about:

- Personal care;
- Routine management of financial affairs;
- Health Care; and
- Obtaining legal services and instructing counsel in relation to certain legal matters.

Section 7 Representatives are not permitted to make decisions about:

- Sterilization for non-therapeutic purposes;
- Refusal of Health Care that is necessary to preserve life;
- The use of physical Restraints; or
- Admission to a licensed Care Facility. For more on care facility admission see the [Consent to Care Facility Admission Policy](#).

8.5.2. Section 9 Representative

Section 9, or Enhanced or Non-Standard Representation Agreements, have a wider scope than Section 7 Representation Agreements. Section 9 Representatives can give or refuse consent to Health Care necessary to preserve life.

8.6. Temporary Substitute Decision Makers (TSDM)

Staff must appoint a TSDM if a Health Care decision is required and an incapable Client:

- Did not create an Advance Directive related to the proposed Health Care; and
- Does not have a Committee of Person; and
- Did not appoint a Representative or the Representation Agreement does not address the specific Health Care at issue.

TSDMs are governed by the Health Care (Consent) and Care Facility (Admission) Act.

8.7. Qualification Requirements for a Temporary Substitute Decision Maker

In order to qualify as a TSDM, a person must:

- Be at least 19 years of age;
- Have been in contact with the Client during the preceding 12 months;
- Have no dispute with the Client;
- Be capable of giving, refusing, or revoking substitute consent; and
- Be willing to comply with the [Duties of a TSDM](#) listed in section 19 of the *Health Care (Consent) and Care Facility (Admission) Act*.

8.8. Choosing a Temporary Substitute Decision Maker

Staff must choose the person highest on the following list who meets the qualification requirements to serve as TSDM:

- The Client's spouse;
- The Client's child;
- The Client's parent;
- The Client's sibling;
- The Client's grandparent;
- The Client's grandchild;
- Anyone else related by birth or adoption to the Client;
- A close friend of the Client; or
- A person immediately related to the Client by marriage.

If no one from the above list is available or qualified, or if there is a dispute about who is to be chosen, Staff must refer the matter to the Public Guardian and Trustee (PGT).

8.9. Limits on Authority of a Temporary Substitute Decision Maker

A TSDM is not permitted to make decisions about the following:

- Abortion, unless recommended in writing by the treating physician and at least one other Medical Practitioner who has examined the Client;
- Electroconvulsive therapy, unless recommended in writing by the treating physician and at least one other Medical Practitioner who has examined the Client;
- Psychosurgery;
- Removal of tissue from a living human body for implantation in another human body or for medical research;
- Experimental Health Care involving a foreseeable risk that is not outweighed by the expected therapeutic benefit for the Client;
- Participation in a Health Care or medical research program that has not been approved by a Research Ethics Committee or Board listed in the [Health Care Consent Regulation](#);
- Any treatment, procedure, or therapy that involves using aversive stimuli to induce a change in behaviour.

A TSDM has the authority to refuse to consent to Health Care necessary to preserve life, but only if there is substantial agreement among Staff caring for the Client that the decision to refuse to consent is medically appropriate.

8.10. Duties of a Temporary Substitute Decision Maker

With respect to all Health Care decisions, the TSDM must:

- Consult with the Client to the greatest extent possible;
- Comply with any instructions or wishes the Client expressed while still capable; and
- If there are no such instructions or wishes, make a decision in the Client's best interests. A best interests decision must consider the Client's current wishes and known values and beliefs.

8.11. Requirement to Revisit Decision Made by Temporary Substitute Decision Makers

The TSDM's consent is valid if the Health Care commences within 21 days. If the course of treatment has not begun within 21 days, Staff must obtain consent from the Client or the TSDM again.

The Client must be asked to confirm the consent decision if the Client regains capability:

- After a TSDM has made a consent decision and before the Health Care has started; or

- While the Health Care is ongoing.

8.12. Disputes or Concerns Regarding a Substitute Decision Maker

Staff should contact the MRP or MRC if they are concerned that a SDM:

- Was not appropriately appointed;
- Is not complying with the Client's previously expressed instructions or wishes; or
- Is not acting in the Client's best interests.

The Public Guardian and Trustee (PGT) has the authority to investigate when there are concerns that a SDM is not performing their duties, or there is a dispute over who should be the TSDM.

Date/Signature:	February 26, 2025		October 28, 2024	
Owners:	Quality and Safety		Legal	
Revision History: <i>(optional)</i>	Version	Date	Description/ Key Changes	Revised By
	2	Apr 4/2025	This is the second version of this policy. Version 1 applied to VCH only and not PHC. Added Appendix A on SDMs. Added a section on requirements related to capability. Updated policy to reflect requirements related to legislation including: <i>Mental Health Act; Human Rights Code; Adult Guardianship Act, Health Care (Consent) and Care Facility (Admission) Act; Child Family, and Community Services Act; Infants Act; Residential Care Regulation.</i>	VCH
	2.1	Aug 20/2025	Small edit that removed the requirement to use Health Care Consent Regulation Form 1: Notice of Incapability and Substitute Consent (Major Health Care).	VCH

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