

The Circle of Care & Consent to Treatment

By Richard Steinecke

On November 1, 2004, the *Personal Health Information Protection Act (PHIPA)*, 2004, came into force in Ontario. The goal of *PHIPA* is to foster effective health care while protecting client privacy. The intent is not to restrict the necessary sharing of information for assessing or treating clients. In fact, it slightly expands the permissible sharing of client health information within the client's health care team – the *circle of care*.

Personal Health Information Protection Act (PHIPA)

Ontario's *Information and Privacy Commissioner (IPC)*, Dr. Ann Cavoukian Ph.D., who oversees the administration of *PHIPA*, describes the purpose of this Act as follows:

"*PHIPA* establishes a set of uniform rules about the manner in which personal health information may be collected, used or disclosed, and includes provisions that:

- Require patient consent for the collection, use and disclosure of personal health information, with necessary but limited exceptions that would allow health care providers to provide efficient care (s.29);
- Require that health information custodians treat all personal health information as confidential and keep it secure (s.13);
- Strengthen an individual's right to access his/her personal health records, as well as the right to correct errors (s.52 and s.55);
- Give a patient the right to instruct health information custodians not to share any part of his/her personal health information with other health care providers (s.20(2));
- Establish clear rules for the use of personal health information for fundraising or marketing purposes (s.32);
- Set guidelines for the use and disclosure of personal health information for research purposes (s.44);
- Ensure accountability by granting an individual the right to complain to the IPC about the practices of a health care organization (s.56);
- Establish remedies for breaches of the legislation (s.61)."

Please see www.cdo.on.ca for the website version of this article with direct links to the appropriate sections of PHIPA.

THE CIRCLE OF CARE

Rose Green was transferred from Central Hospital to Quiet Acres Manor, a long term care facility. Barbara, a Registered Dietitian from Quiet Acres, has to prepare a dietetic treatment plan to address Rose Green's diabetes and obesity. Rose Green is no longer capable and her substitute decision maker, a niece, is unavailable for a month. While not an emergency situation, Barbara wants to implement a dietetic plan within days, not weeks. Barbara needs more information and notices that her classmate, Jennifer, was the Registered Dietitian on record at Central Hospital. Barbara calls Jennifer to see if she can provide a more detailed history and any suggestions for managing Rose Green's nutritional needs.

Can Jennifer help?

Sharing of Health Information & the Circle of Care

Prior to *PHIPA*, Jennifer may not have shared any client information with Barbara without explicit consent from the client's substitute decision maker. As this was not an emergency and there was no expressed consent, such a disclosure would not have fallen within any established exception to Jennifer's general duty of confidentiality. Practitioners like Jennifer were hesitant to imply consent for disclosure of information between institutions without some prior discussion with their client or their client's substitute. Since the inception of *PHIPA* in November 2004, this has changed.

While the term does not actually appear in the act, *PHIPA* introduces the concept of the *circle of care*. Dr. Ann Cavoukian explains the rationale for the *circle of care* concept as follows:

"The "circle of care" is not a defined term under *PHIPA*. It is a term of reference used to describe health information custodians and their authorized agents who are permitted to rely on an individual's implied consent when collecting, using, disclosing or handling personal health information for the purpose of providing direct health care.

In a physician's office, the circle of care would include:

- the physician;
- the nurse;
- a specialist or other health care provider referred by the physician; and

- any other health care professional selected by the patient, such as a registered dietitian, pharmacist or physiotherapist.

In a hospital, the circle of care would include:

- the attending physician; and
- the health care team (e.g., residents, nurses, registered dietitians, technicians, clinical clerks and employees assigned to the patient) who have direct responsibilities of providing care to the individual.

The circle of care does not include:

- A physician who is not part of the direct or follow-up treatment of an individual;
- A medical officer of health or a board of health;
- An evaluator under the *Health Care Consent Act, 1996*;
- An assessor under the *Substitute Decisions Act, 1992*;
- The Minister, together with the Ministry of Health and Long-Term Care; and
- The Canadian Blood Services."

The Health Information Custodian

Personal health information practices that comply with *PHIPA* and its regulations are set by health information custodians. A custodian is generally the institution, facility or the health practitioner that provides health care to an individual. Under the *circle of care* concept, a custodian (or their agent) is able to share personal health information with another custodian (or their agent) for the purpose of providing health care even without express consent. Disclosure for

treatment purposes would be barred only if the client, or the client's substitute, had indicated that the information not be shared. A custodian can enhance the implied consent aspects of the *circle of care* by describing it in their privacy policies and materials (e.g. brochures, posters and websites).

Express client consent is required to disclose personal health information to a non-custodian but is not necessary for disclosure within the circle of care for treatment purposes. However, because of past practices and the heightened importance of privacy of personal health information, Jennifer might want assurances from Barbara about the legitimacy of her need for the information. She might ask Barbara to put her request in writing and to confirm that Barbara's facility is, in fact, a health information custodian. Since Jennifer also has an obligation to comply with her own employer's privacy policies, she may wish to review them and to confer with her privacy officer to ensure that there are no applicable internal rules.

Once custodians become comfortable with the *circle of care* concept introduced by *PHIPA*, disclosure to help in the treatment of clients like Rose Green should flow more easily than in the past. Thus, the *circle of care* concept will assist in the assessment and treatment of clients. The provisions of *PHIPA* that support the *circle of care* concept are set out in the website version of this article at www.cdo.on.ca.

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CONSENT TO TREATMENT

Barbara develops her treatment plan and then realizes she does not have consent to implement it. After tracking down Rose Green's niece, Tulip, in India for consent, Barbara determines not to be left in a similar position again. When Tulip returns, Barbara asks for broad written consent. Tulip is only too happy to oblige and signs two forms, one permitting Quiet Acres to provide "any treatment that it, in its discretion, believes is in the best interests of Rose Green". The second form authorizes "any health information custodian to disclose information about the medical history, assessment results or treatment of Rose Green that would reasonably assist Quiet Acres, a long term care facility, to provide health care to Rose Green".

Are these consent forms valid?

Consent to Treatment Form

There is serious doubt that the broad consent to treatment form described in the scenario above would be legally valid. It has no specificity whatsoever. In theory, it could permit virtually any treatment of Rose Green that *Quiet Acres* honestly believed was in her interest even if the treatment was unreasonable, by any objective measure. Further, to the extent that the treatment had material risks and side effects, it can hardly be said that the consent obtained was informed.

Consent for treatment must be specific and informed. A specific and informed plan of treatment would likely be valid and could be implemented for a reasonable period of time. In this context a year would be reasonable assuming that there were no significant changes in Rose Green's circumstances. With this in mind, Barbara should:

1. Map out a plan of treatment identifying likely components including foreseeable treatment challenges and known risks and side-effects;
2. Discuss the proposed plan of treatment with Tulip;

3. Document the discussion;
4. Ask Tulip to sign a consent form outlining the major components of the plan; and
5. Refresh the plan of treatment and consent process on an annual basis.

Disclosure of Personal Health Information Form

In terms of the second form permitting disclosure of personal health information to *Quiet Acres*, validity would be much more likely because:

1. The form provides for an objective test of what information is requested — personal health information that would reasonably permit a long term care facility to provide treatment to Rose Green;
2. The consent relates to a relatively known quantity, Rose Green's past health information, and it is not as open ended as the prospective treatment consent; and
3. The *Personal Health Information Protection Act*,

2004, ss. 20(1), permits practitioners to assume that a written consent form is valid unless it is unreasonable to do so.

While PHIPA allows for more sharing of information inside the circle of care, it also establishes clear guidelines for consent and the protection of client privacy. As custodians of their clients' personal health records and information, health professionals are responsible for breaches of legislation. Health professionals must know the law, its implications for their practice and any policies enforced in their workplace to ensure privacy protection, client care, and informed consent.

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