Dr. Mariam Hanna:
Hello, I'm Dr. Mariam Hanna, and this is The Allergist, a show that separates myth from medicine, deciphering allergies and understanding the immune system. Consent is one of the most familiar words in medicine, and one of the most misunderstood. We ask, did you get consent? Is it documented? But in practice, consent is rarely just a signature.

It's a nuanced, high-stakes conversation shaped by risk, uncertainty, and clinical judgment. Consider a typical allergy clinic scenario. A teenager sits with her parents, deciding about subcutaneous aro-allergen immunotherapy.

You explain the benefits, better symptom control, potential long-term disease modification. Then you review the risks. A large local reaction is common, systemic symptoms could happen, but the rare but real possibility of anaphylaxis requiring epinephrine.

You outline the post-injection observation period, the multi-layer commitment that they're about to make, and alternatives, just like continue pharmacotherapy. It's no big deal. The parent nods.

The patient hesitates. You pause. You clarify.

You invite any questions that might be in the room. They decide to proceed. But consent doesn't end with agreement.

What do you document? The risks were quote-unquote reviewed? That anaphylaxis was explicitly discussed? That alternatives were presented and understanding confirmed? As expectations around shared decision-making and medical-legal accountability evolve, consent is no longer just a checkbox. It's a core clinical competency. Today, we're examining what meaningful consent looks like in practice.

It's my pleasure to introduce Dr. Lisa Thurgur. She's an assistant clinical professor at the University of Ottawa. Dr. Thurgur holds Royal College certification in both emergency medicine and clinical pharmacology and toxicology.

She's an award-winning educator and emergency physician. Now with the Canadian Medical Protective Association, CMPA, Dr. Thurgur brings extensive expertise in medical-legal education, medical-legal risk, and physician support, making her exceptionally well-qualified to speak on consent in contemporary clinical practice, which is today's topic. Dr. Thurgur, thank you so much for taking time out of your schedule, and welcome to the podcast!

Dr. Lisa Thurgur:
Thanks so much, Mariam.

Dr. Mariam Hanna:
Let's start with what legally constitutes valid consent in Canadian practice?

Dr. Lisa Thurgur:
That's a great question and that's sort of what starts off the conversation for this. Really, I mean, we learn about this in med school, to be honest, and then sometimes I think we forget about it, but valid consent, it really involves three key elements. Consent has to be voluntary, the patient must be properly informed, and the patient really also has to have the capacity to be able to consent.

And then, I mean, the next question probably is what does that mean to have the capacity to be able to consent? Well, again, that has three components as well. So to be considered to have the capacity to consent, you have to have, you have to understand the nature of the proposed investigation or the treatment that you're going to perform, the anticipated effects of this treatment needs to be explained, and the alternatives of that, and they have to be able to appreciate the consequences of refusing treatment.

So essentially, the patient needs to be able to understand what's proposed and why, the risks and the alternatives of that, and then the potential consequences of their decision.

Dr. Mariam Hanna:
Okay, simple but not. And despite saying like capacity, voluntary understanding of what's going on, we still get a lot of consent-related complaints, as I understand, in the CMPA. So from your side, what are the most common consent-related complaints that are received at the CMPA level?

Dr. Lisa Thurgur:
Yeah, you're absolutely right, Mariam, and that's why I'm glad we're talking about consent, because inadequate consent discussions are frequent allegations in the medical legal cases that we see at the CMPA. We're fortunate to have a lot of medical legal data from all across Canada, which our incredible CMPA research team dives into and explores, and certainly consent is a topic that comes up frequently in both college complaints as well as civil legal actions. And so it is common.

We see it regardless of what specialty you practice, and that's why it's such a hot topic to talk about. And when you dig even deeper into these cases, it really just comes down to communication. Our studies have shown that better patient-physician communication really will lead to improved adherence of all of the treatments and therapies that you want to start in the first place.

Better communication leads to better health outcomes and also to reduced risk of medical legal actions. So informed consent is, it's not only a physician's duty, it really is rooted in patient autonomy or, you know, it sounds dramatic, but an individual's right to mastery of their own body. So respecting that autonomy requires a relationship of trust and really an open two-way dialogue or conversation that can happen where the patient can actually share their fears and their concerns and the particular patient's circumstances.

Dr. Mariam Hanna:
So it comes down all to, like, communication complaints, it sounds like. Isn't it just good enough to get them to sign on their informed consent? We discussed it and they signed it.

Why is that not equivalent?

Dr. Lisa Thurgur:
Yeah, I mean, communication, you mentioned that it comes down to communication complaints. It does, but a lot of the complaints are specific to the inadequate consent process. And, I mean, I think if I'm going to give your listeners one big message, it is exactly what you're asking.

Is a signed consent form enough? We often think of getting consent as like a task or a checkbox that needs to get ticked or something we do or that we can just get done so we can go on and carry about the more important part of medicine or the procedure that we want to do. But I'd really, you know, like to suggest that we should try to think about consent as a process or a discussion or a conversation that you have with the patient.

Because the message is that consent really is more than a signed consent form. It's important to make it a conversation to ensure that the patient is informed, that they understand the risks, you know, including the risk of no treatment at all or no procedure at all, and that they understand the alternatives. And most importantly, that they have the chance to ask questions.

So that's why consent is a process in itself.

Dr. Mariam Hanna:
Okay. So it's a process, and then I need to review it every single time. So some of my patients that come in for immunotherapy, for example, they're in the office once a week for their shots.

Isn't it implied when they walk in for their appointment that that's what we're doing that day?

Dr. Lisa Thurgur:
Yeah, that's a good question. Certainly, we get asked that a lot about do I have to consent every single time? I'm essentially providing the same treatment.

And you mentioned, is it implied or is it expressed? And those are the two types of consent that we're talking about, right? Consent can be implied or it can be expressed.

And examples of implied consent are things like, I mean, it's when their words or their behavior indicate that they consent to what you're about to do. So things like volunteering answers to questions when you take a medical history or submitting to a simple, non-sensitive physical exam without any objection. Those are more implied consent behaviors.

But express consent needs to occur either verbally or in writing when whatever you're doing carries a little bit more risk. So say you're performing a procedure, particularly procedures that

are painful, or you're starting a therapy, a new therapy, or performing a sensitive exam. This is when the patient should be asked to express their consent formally.

And in the world of allergies, I think that a lot of things that you do would probably require express consent. Now, you did ask, does this have to happen every time? It doesn't.

Assuming that you're performing and doing the same sort of types of things that the patient consented to the first time. But it is the responsibility of the physician to get a sense of if things have changed, if the patient's feelings about it have changed, and then decide about if another consent discussion in a different way needs to occur.

Dr. Mariam Hanna:
Okay, fair enough. And can we get in trouble with overestimating, like, implied consent?

Dr. Lisa Thurgur:
Well, unfortunately, I don't have a crystal ball about whether or not you can get in trouble for that. We get asked that a lot. Remember, the CMPA doesn't set standards.

We give you tips on how to improve patient safety and minimize risk. But if in doubt, ask the questions again, would be our best advice. Again, it comes down to communication, and it comes down to having that physician-patient relationship where you attempt to understand what might need to change in that consent conversation.

Okay.

Dr. Mariam Hanna:
We often discuss with consent what a reasonable person would want to know, and it doesn't necessarily speak to how frequent of an occurrence it is. It's just what a reasonable person would want to know.

Dr. Lisa Thurgur:
You're absolutely right. In fact, that's where the whole premise of consent comes from is a sense of reasonableness, and that's what we use to remind physicians about the types of information, the points and the bits of information they should include in their consent conversation is what would a reasonable patient want to hear. And it's important to think and put yourself or a family member in the position of being a patient and remove our sort of medicine hat at the top of time about what we know and what we think we understand and people understand, but instead what a reasonable patient would want to know.

The different types of risks, because there really are two types of risks when you're explaining a consent process to patients. There's material risks, and then there's special risks. And the material risks include, you know, things that frequently occur or the things that might be rare, but perhaps are more serious, like in your world, it would be anaphylaxis or death.

And you listed quite a few in your introduction and introductory case for sure. Those are the material risks, the more common things or the rare things, but that are serious. These special risks are risks that are particularly relevant to that specific patient, and these aren't seen as material.

They're more special circumstances that require a discussion specifically for that patient.

Dr. Mariam Hanna:
How do we avoid under-disclosing but not overwhelming the patients? For a great example is with subcutaneous immunotherapy, as we're talking about. Aeroallergen immunotherapy can be associated with anaphylaxis, and one of the severe anaphylaxis includes death.

Should I be saying that?

Dr. Lisa Thurgur:
I think how you just said it to me is absolutely perfect, Mariam. And unfortunately, that is part of the conversation that has to happen. When patients allege that inadequate consent has not happened, part of the allegation is that they weren't informed about all of the potential harms or consequences.

So if it is a does have to be mentioned, I can completely appreciate how that discussion can be alarming to parents to hear that. And I would imagine, given that you have these conversations quite often, patients and parents and guardians often understand the fact that you do need to disclose that.

Dr. Mariam Hanna:
Okay, understood. How can minors meaningfully participate in consent discussions? Is there an age?

Is there a time in their life when they can meaningfully, actively participate in these discussions versus not?

Dr. Lisa Thurgur:
Yeah, we get a lot of calls, physicians calling to ask about mature minors or age of consent, and it's okay to wonder because it's not straightforward. But physicians should know that essentially the criterion for capacity to consent is actually maturity. It's not chronological age.

So there's no exact age. A young person is considered to be capable of consenting or refusing treatment if, you know, they have the mental and the emotional development to allow for the full appreciation of the nature and consequences of the decision. So it's not chronological age.

It's maturity. There is one exception to this, and this is in Quebec, where the parent or the guardian must consent if the child is under the age of 14.

Dr. Mariam Hanna:
Okay. What about in the events of disagreement, either disagreement between the parents or if the minor doesn't agree? How do we go about that?

Dr. Lisa Thurgur:
So those are tricky, absolutely. I mean, generally, if you've decided that a patient is a mature minor, I would still, as a physician, probably do my best to stress to the patient the importance of really involving their parents in the discussion and the procedure and the treatment or the visit in general. So I would try to get involvement with the parents as well.

If there are disagreeing parents, those get really tricky. And these are times when we would advise that the physician calls the CMPA and speaks with a physician advisor on the phone, because it really does depend on the facts and the circumstances of the case. And as I mentioned, they can get quite complicated.

Dr. Mariam Hanna:
Okay. And the documentation of all this, how is this documented in the medical record appropriately?

Dr. Lisa Thurgur:
I just think it's important to stress that the consent discussion itself needs to be documented in the chart. We often, physicians will have the consent discussion, perhaps get a signed consent form, but it's good to make a note in the chart reflecting the conversation. It doesn't need to be a long note, but it really should reflect the conversation that you had, the mention of the different kinds of risks that we talked about, any special risks for that patient, any questions that the patient or the parents or guardians had.

If you had to give any consideration to capacity in that particular situation, it would be important to document any consideration that went into that, to reference any handouts that you provided the patient. All of those things should be part of the consent note, because when you personalize the consent documentation, it gives validity to your consent procedure. And if your consent note is more personalized, it does make it difficult for patients to allege that you did not have that consent conversation.

If a peer expert were to go back and review your chart in the event of a college complaint or a legal action surrounding consent, that personal note with a few details really does add validity to your consent discussion. Now, if there is disagreement between parents or guardians about going ahead with the therapy or the procedure, it's very important to document that. We recommend that you keep that documentation very objective, very factual, using quotes if you can, so don't try to assume what the patient or what the guardian was feeling or the parent was feeling, but write down exact words and keep it very objective.

And then, as I mentioned, these are trickier scenarios, so we would advise that you call the CMPA and speak to a physician advisor.

Dr. Mariam Hanna:
Okay, fair enough. And you have to explore with the patient exactly why they are declining? It's not good enough for them to just say, no, I don't want this?

Dr. Lisa Thurgur:
I think it would be in the physician's best interest to explore it. Often, it might be due to the fact that they still have questions, they're still unsure, they have fears surrounding it. So again, this speaks to the communication that's very important in the consent discussion and finding out perhaps why the patient or the parents or guardians didn't want to proceed with the therapy.

Dr. Mariam Hanna:
Okay. And then I think a lot of physicians are quite comfortable with the use of AI scribes and these types of technologies, and we understand the importance of disclosing that to families and allowing them the opportunity to agree or decline if they want that used during the encounter. What about the opposite?

So in the world of high-tech and the need to remember all the information that patients are receiving, I do have patients that record. Sometimes they'll ask me and sometimes I'll just notice it as we are having our discussion. What are the implications of this?

What should be done around this topic?

Dr. Lisa Thurgur:
This is common as well, not only in the allergy world, but in a lot of medicine, certainly where patients want to record their visit or their interaction. And although physicians, as physicians, we need consent for much and most of what we do with our interactions with our patients, physicians are very surprised to know that patients do not need our consent to video the interaction. Now, I think it's important to, again, have the conversation with patient about why they want to video the interaction or the procedure.

Often it's so that they don't forget any instructions you're giving them. Maybe they think, you know, your allergen challenges are quite cool, that the scratch tests are interesting and they want to show a friend, whatever it might be. It's important to ask why they want to video or record the interaction and try and get a sense of that.

If they do record your interaction, it's important to ask for a copy of that and then it's important to include that in the chart. But yes, patients do have the right to record their interaction with you.

Dr. Mariam Hanna:
Fair enough, but it's nice to know when it's happening. Okay, documentation is, I would say, a central theme to consent as well as communication. But on the physician side, we also worry about how to document this.

Can you give us, as physicians, like a documentation habit that I should adopt tomorrow to strengthen my consent practice?

Dr. Lisa Thurgur:
Yeah, absolutely. I mean, documentation is huge and at the CMPA, we talk about documentation all the time. I'm going to give you one tip and hopefully it's not causing some eye rolls when I do it, but we really find that this tip helps physicians not only structure their consent conversation, but also structure their documentation.

So, we like to use the mnemonic PARQ. P-A-R-Q. P is for the procedure that you're going to explain, all the details of that.

A is for any alternatives that you offer the patient, including the alternative of not having the procedure or the therapy to begin with. R for the different risks, both the material and the specific risks that we talked about. And then Q is the opportunity for them to have questions.

And the ones that physicians often forget about are the A and the Q, so we really do want to emphasize those. And then when you're writing your note in the chart, you can use PARQ just to write a line or two about each one. Again, it personalizes your note, it adds validity to your note, and it makes it more difficult for patients to allege that you didn't have that conversation because you've documented it in that way.

One last tip about the consent discussion and documentation of it is to then have the patient read back or repeat back what you discussed. So, you might want to say something like, what did you understand from our discussion today? You'd probably be just, you know, surprised about what little they do understand, but it gives you a sense of any uncertainty they have.

If they understood the conversation, it gives them another chance to ask questions. And again, that wholesome conversation that you take a minute or two to go through really creates a physician-patient relationship, expands that communication, and probably will not only improve patient outcomes, but reduce medical legal risk for physicians in the consent process.

Dr. Mariam Hanna:
Fabulous. Well, I mean, that's what we wanted to accomplish with today's discussion, so that's a perfect way to end. All right, time to wrap up and ask Dr. Lisa Thurgur for her top three key messages to impart to patients and physicians on today's topic, consent in clinical practice.

Dr. Lisa Thurgur:
Dr. Thurgur, over to you. So, Maryam, I'd say number one is that consent is not just a signed consent form. We need to understand that it's a process and it involves a discussion and a dialogue with the patient.

The second takeaway would be, what does this discussion involve? And a reminder that the consent discussion involves what a reasonable patient in similar circumstances would want to

know before consenting to the procedure or the therapy. And I would say my third takeaway is that if you find yourself with a complicated consent question or any question at all, really, give the CMPA a call.

You don't have to be dealing with a college complaint or a legal action to call us. We give advice to our members all the time. We have physician advisors who understand and appreciate both the medical and the legal part of what you do, and we are always here to help.

Dr. Mariam Hanna:
Amazing. Thank you, Dr. Thurgur, for joining us on today's episode of The Allergist.

Dr. Lisa Thurgur:
Thanks so much, Mariam

Dr. Mariam Hanna:
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P-A-R-Q. Thanks for listening. Sincerely, The Allergist.