Practice Standard: Consent to Treatment

Applies to Traditional Chinese Medicine Professionals & Acupuncturists

The College of Complementary Health Professionals of BC was created on June 28, 2024 through the amalgamation of four health regulatory colleges:

- College of Chiropractors of BC
- College of Massage Therapists of BC
- College of Naturopathic Physicians of BC
- College of Traditional Chinese Medicine Practitioners and Acupuncturists of BC

All current requirements for standards of clinical and ethical practice issued by the four colleges remain in place upon amalgamation.

This document was created by the College of Traditional Chinese Medicine Practitioners and Acupuncturists of BC and will be updated to reflect the amalgamation.

College of
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PRACTITIONERS +
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of British Columbia

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Practice Standard on Consent to Treatment (Updated: December 01, 2022)

Practice Standards of the College of Traditional Chinese Medicine Practitioners & Acupuncturists of British Columbia (the "College") set out minimum requirements for the professional conduct of TCM professionals practising in British Columbia. Together with the *Jurisprudence Handbook* and relevant legislation and case law, they will be used by the College and its Committees when considering practitioner practice or conduct.

Within the Practice Standard, the term 'must' is used to indicate a College requirement and the term 'advised' is used to indicate that the practitioner can use reasonable discretion when applying this expectation to practice.

Definitions

Consent to treatment: The voluntary agreement of a patient or substitute decision-maker to a specific proposed assessment, treatment, or procedure which can be withdrawn at any time.

Implied consent: Consent communicated through non-verbal actions.

Capacity: A person has the ability to understand the information that is relevant to making a decision about the proposed assessment, treatment or procedure and can appreciate the reasonably foreseeable consequences of a decision or lack of decision of accepting or refusing the proposed assessment, treatment, or procedure. Capacity to consent to a treatment can change over time. The capacity varies according to the individual patient and the complexity of the specific treatment decision.

Minor: A person under the age of 19.

Mature Minor Consent: This is the consent that a minor gives to receive or refuse a proposed assessment, treatment or procedure after a practitioner determines they understand the nature, consequences and reasonably foreseeable benefits and risks of the proposed assessment, treatment, or procedure.

Substitute decision-maker: A person authorized to give or refuse consent to treatment on behalf of a patient who lacks capacity.

Standard

The practitioner **must** practice in accordance with the following requirements:

General Principles

1. The practitioner is aware of, and is in compliance with, all of the requirements in the *Health Care (Consent) and Care Facility (Admission) Act (HCCCFAA)* and the *Infants Act.*
2. Consent to health care can be given or refused in three ways: written, verbal, or implied.
3. The practitioner obtains a valid consent before a proposed assessment, treatment, or procedure is provided. That consent is specific and cannot be assumed based on previous consents given or generic consents that are not specific to the proposed intervention.
4. The patient has the right to refuse or withdraw consent to treatment at any time, and the practitioner respects the patient's decision to choose what to consent to and what to refuse.
5. As part of ongoing communication with a patient, the practitioner checks with the patient to reconfirm consent when there are any signs that the patient's understanding of or wish to receive an assessment, treatment, or procedure has changed. The practitioner adjusts the communication approach for each patient to ensure that the information and explanations are clearly understood by the patient.[1]

Determining Capacity to Give Consent

6. When obtaining consent for treatment, the practitioner ensures that the patient is capable of giving consent. The practitioner is entitled to presume capacity unless there are reasonable grounds to believe the patient lacks capacity to consent to treatment (e.g., something in a patient's history or behaviour raises questions about their capacity to consent to treatment).
7. The first step in determining the test for capacity is to consider whether the patient is able to understand the information that is relevant to making a decision about the proposed intervention. The patient needs to be capable of intellectually processing the information as it applies to them, including the potential benefits and risks. The second step in determining capacity is whether the patient is able to appreciate the reasonably foreseeable consequences of a decision or lack of decision to accept or refuse the proposed intervention.
8. The practitioner considers the patient's capacity at various points in time and in relation to the specific assessment, treatment, or procedure being proposed.

<u>Incapable Patients and Substitute Decision-Making</u>

9. Where there are reasonable grounds to conclude that a patient is incapable of giving informed consent to treatment, the practitioner, where possible, informs the patient who lacks capacity that a substitute decision-maker will assist them in understanding the proposed assessment, treatment, or procedure and that the substitute decision-maker will be responsible for the final decision. When appropriate, the practitioner needs to involve the patient who lacks capacity to the fullest extent possible, in discussions with the substitute decision-maker. A substitute decision-maker is chosen according to the priority and qualification specified in section 16 of the *Health Care (Consent) and Care Facility (Admission) Act*.

[1] According section 8 to *<u>Health Care (Consent) and Care Facility (Admission) Act</u>* *(HCCCFAA),* the practitioner has a duty to communicate in a manner appropriate to the patient's skills and abilities.

10. The practitioner documents the substitute decision-maker’s name and contact information in the patient’s clinical file.

Minors

11. If a minor is capable of giving consent to treatment, the practitioner accepts that consent directly without obtaining consent from the minor's parent or guardian.
12. The test for capacity to consent to a treatment is not age-dependent and, as such, the practitioner makes a determination of capacity for a minor just as the practitioner would for an adult when accepting a mature minor consent.
13. The practitioner obtains consent from a parent or guardian if the minor does not have capacity to provide consent to treatment.

Obtaining and Documenting Consent

14. For consent to treatment to be valid, the practitioner ensures that:
    a. The consent is directly obtained from the patient or from the patient’s substitute decision-maker, if the patient lacks capacity to consent to treatment.
    b. The consent is informed and includes the following elements:[2]
        - Nature of the proposed assessment, treatment, or procedure
        - Who will be performing the proposed assessment, treatment, or procedure
        - Rationale for the proposed assessment, treatment, or procedure
        - Potential risks and benefits of the proposed assessment, treatment, or procedure
        - Alternatives to the proposed assessment, treatment, or procedure
        - Notification to patient of their right to refuse or withdraw consent at any time
        - Consequences of not having the proposed assessment, treatment, or procedure
        - Notification to patient of their right to ask questions and receive answers about the proposed assessment, treatment, or procedure.
    c. The consent is given voluntarily, without coercion, fraud, or misrepresentation.
    d. The consent relates to the specific assessment, treatment, or procedure being proposed.
    e. The practitioner discusses consent with the patient or the substitute decision-maker (as the case may be) when providing the information specified in section 14(b), ensures the information provided is understood, and, as such, takes reasonable steps to facilitate comprehension of the information provided.
15. The practitioner documents the receipt, refusal, or withdrawal of consent for treatment in the clinical record.

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[2] Adapted from the *Jurisprudence Handbook* *(page 11*) and Section 6 of the *HCCCFAA.*

16. For follow-up treatments or procedures with no change to the initial treatment plan, the practitioner will ensure that the patient's previous consent is still valid. If there is a change to the treatment plan (for example, a new procedure is introduced) that is not covered by the previous consent, the practitioner needs to obtain consent for the change to the specific course of treatment or procedure.[3]
17. The practitioner documents any concerns raised during the consent process and actions taken to address them (e.g., a patient is determined to be incapable of providing consent and an authorized substitute decision-maker is identified) in the clinical record.
18. The practitioner documents the rationale and decision when a mature minor consent is accepted in the clinical record.

Practice Advice

It is advised that the practitioner communicate in a manner appropriate to the patient's culture, language, and personal preferences. For example, the practitioner can use plain language, age-appropriate terminology, and qualified interpreters (if appropriate) to ensure the patient has an adequate understanding in order to make their own decision to give or withdraw informed consent to treatment.

The practitioner is advised to consider and address language and/or communication issues that may impede a patient's ability to give valid consent and to obtain independent legal advice if they are unsure of their legal obligations in relation to consent to treatment.

The use of written consent forms is encouraged. If a written consent form is used, the patient's name, signature, and date of signature should be included in the record, in addition to the elements of informed consent outlined in section 14(b).

Some professional liability insurance providers may require the practitioner to include specific provisions in the consent form outlining specific health risks to a patient in advance of providing the treatment and may decline to indemnify the practitioner in the absence of such provisions. One such example for acupuncture is mentioning the risk of pneumothorax. The practitioner is advised to review the terms of the practitioner's professional liability insurance policy.

Adapted from and thanks to:

College of Physicians and Surgeons of BC

https://www.cpsbc.ca/files/pdf/NHMSFAP-AS-Consent.pdf

College of Physicians and Surgeons of Ontario

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[3] According to Section 9.2 of the *HCCFAA*, consent to health care applies only to the specific health care that a patient has consented to.

https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Consent-to-Treatment

British Columbia Ministry of Health

https://www.health.gov.bc.ca/library/publications/year/2011/health-care-providers'-guide-to-consent-to-health-care.pdf

Resources

College of Traditional Chinese Medicine Practitioners & Acupuncturists of British Columbia (2016). *Jurisprudence course handbook.* Available from: https://www.ctcma.bc.ca/media/1063/jurisprudence-handbook-en-web.pdf

College of Traditional Chinese Medicine Practitioners & Acupuncturists of British Columbia (2016). *Clinical Record Keeping Sample Form.* Available from: https://www.ctcma.bc.ca/media/1639/clinical-record-keeping-practice-standard-sample-forms.docx

Government of British Columbia. *Health Care (Consent) and Care Facility (Admission) Act*, [RSBC 1996], Chapter 181. Available from: https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96181_01

Government of British Columbia. *Infants Act*, [RSBC 1996], Chapter 223. Available from: https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96223_01.

中文翻译仅供参考， 如与英文文意有出入，则以英文版本为准。

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有关同意治疗的执业准则

卑诗省中医针灸管理局（简称管理局）的执业准则确立注册成员在提供传统中医治疗服务前必须达到的最低专业能力水平，管理局与旗下各委员会通过执业准则、法理学课程手册和其他相关法令，以评断注册学员的执业水平与专业行为。

在执业准则中，“必须”这个词代表管理局的要求，“建议”这个词表示管理局的期望，注册成员可以自行运用合理判断做决定。

定义

同意治疗：病患或其代做决定者自愿同意接受执业医师建议的诊断或治疗，病患或代做决定者可以随时撤回同意。

默许的同意：通过非语言的行动所表达的同意

能力：一个人有能力了解与诊断或治疗有关的信息，这类信息帮助患者决定是否同意治疗，所谓的能力也表示可以理解决定接受诊断与治疗或决定不接受诊断与治疗可能预见的后果。同意治疗的能力可能随着时间的推移而改变，此外，个别患者与特定治疗决定的复杂程度也会影响做决定的能力。

未成年者：19 岁以下的人

成熟未成年者的同意：未成年者同意接受或拒绝诊断与治疗，但是执业医师必须先确定未成年患者已经了解诊断或治疗的性质、后果，以及可以预见的风险和好处。

代做决定者：经授权替没有做决定能力的患者来决定接受或拒绝治疗

标准

执业医师**必须**遵循以下要求来执业：

一般原则

1. 执业医师明白并遵守医疗（同意）与医疗照护设施（住院）法(HCCCFAA)和婴儿法中所有的要求。
2. 患者可通过三种方式同意或拒绝治疗：书面、口头或默许。

3. 执业医师在进行诊断或治疗前取得有效的同意，所谓有效同意必须有针对性，不可以根据过去取得的同意或是广泛的同意，而是针对每一次特定的治疗所做的同意决定。

4. 任何时间病患都有权利拒绝治疗或撤回治疗同意，执业医师尊重病患同意治疗或拒绝治疗的决定。

5. 执业医师与病患持续保持交流，在这过程中，医师如果发现患者对诊断或治疗的理解或意愿有所改变，那么就应当重新确认患者的同意。每个病患不一样，医师据此调整沟通方式，以确认病患明确了解医师提供的信息和说明。[1]

确认病患提供治疗同意的能力

6. 执业医师在取得病患同意时，先确定病患本人有能力做出同意决定。医师可以假定病患有此能力，除非有合理理由认为病患没有做出治疗决定的能力（例如：病患过去的病历或行为值得医师怀疑病患同意治疗的能力）。

7. 测试病患是否有能力做决定的第一步是确认病患是否了解与治疗有关的信息，病患需要具备消化与其病情和治疗相关信息的能力，尤其是理解治疗所带来的潜在好处与风险。测试病患是否有能力做决定的第二步是确认病患是否能理解决定与否的后果，不论是接受或不接受医师的治疗建议，都能理解可能预见的后果。

8. 执业医师在不同的时间点考量病患针对特定诊断或治疗建议做决定的能力。

没有决定能力的病患与其代做决定者

9. 如果执业医师有合理的理由认定病患本人没有能力给与知情同意，那么如有可能应告知病患让一个代做决定者予以协助，以了解医师建议的诊断或治疗，同时让病患知道代做决定者将替病患做最后决定。执业医师在与代做决定者进行讨论时，应当尽量让缺乏决定能力的病患参与，至于如何选择代做决定者，医疗（同意）与医疗照护设施（住院）法第 16 节注明了代做决定者的挑选优先次序与应有的资格。

10. 执业医师在病患的病历纪录中记下代做决定者的姓名和联系方式。

未成年者

11. 如果未成年病患有能力给与医师治疗同意，执业医师可直接接受该同意，无需病患的父母或监护人的同意。

[1] 根据医疗（同意）与医疗照护设施（住院）法第八节, 执业医师有责任以适用于病患能力和水平的方式与病患沟通。

12. 病患是否有能力做出治疗同意与年龄无关，因此执业医师在确认未成年病患是否有能力做决定时，也当将病患视为成人看待。
13. 如果未成年病患没有能力提供治疗同意，执业医师应当取得病患父母或监护人的同意。

取得并记录病患同意

14. 在以下的条件下病患同意才算有效：
    a. 病患直接提供医师同意，如果病患没有做决定的能力，其代做决定者直接提供医师同意。
    b. 治疗同意为知情同意，并且包括以下要素：[2]
        - 建议诊断或治疗的性质
        - 谁来进行建议的诊断或治疗
        - 建议诊断或治疗的原因
        - 建议诊断或治疗的潜在风险和好处
        - 可以取代建议诊断或治疗的替代方案
        - 告知病患他们任何时候都有权拒绝或撤回同意
        - 不接受建议诊断或治疗的后果
        - 告知病患他们有权针对建议诊断或治疗提出问题，并有权获得医师的解答。
    c. 病患同意是出自自愿，医师不得通过胁迫、诈欺或误导取得病患同意。
    d. 病患的同意是针对医师建议的特定诊断或治疗
    e. 执业医师提供病患或其代做决定者讨论诊断或治疗同意，提供医疗（同意）与医疗照护设施（住院）法第 14(b)节所注明的信息，并采取合理的步骤以确认病患或其代做决定者充分了解所提供的信息。
15. 执业医师在病患病历中详实记录病患同意或拒绝治疗，或撤回同意的细节。
16. 执业医师进行追踪治疗时，尽管最初的治疗计划没有变更，仍需确认原有的病患同意依然有效。如果治疗计划有变（例如：医师将采取新的治疗方式），而且新的治

[2]. 节录自法理学课程手册（第 11 页）和医疗（同意）与医疗照护设施（住院）法第六节。

疗计划不在当初的治疗同意中，执业医师需要针对特定的治疗计划变更另行取得病患同意。[3]

17. 执业医师取得病患同意后，应在病历中应记录任何有关病患同意的变化与顾虑，并采取行动应对解决。（例如：病患不再有能力提供治疗同意，而且已有一名经授权的代做决定者。）

18. 执业医师如果接到未成年病患的治疗同意，须在病历中记录该病患的决定与背后原因。

执业建议

建议执业医师以适合病患文化背景、语言与个人偏好的方式进行沟通，例如：医师可以使用简单易懂、适合病患年龄的语言，或是通过翻译人员（如果适用的话），以确定病患充分了解医师所言，以便做出同意治疗或撤回同意的决定。

语言障碍或沟通障碍可能阻碍病患提供有效治疗同意的能力，建议执业医师考虑这类问题，如果不确定自身与病患同意相关的法定义务，建议医师需求独立的法务咨询。

病患同意最好是书面同意，同意书上应注明病患姓名，由病患签字并注明签字日期。同意书应与第 14(b)节明列的知情同意要素一起附在病患病历中。

某些提供专业责任险的保险公司可能要求执业医师在病患同意表格中注明病患可能会有的健康风险，如果没有如是注明，保险公司可能拒绝理赔。举例来说，进行针灸治疗前，应向病患提及针灸的可能风险是气胸。建议执业医师仔细了解其专业责任险保单条款。

以上内容根据下列文件摘要改写，谨此致谢：

卑诗省内科医师与外科医师管理局

https://www.cpsbc.ca/files/pdf/NHMSFAP-AS-Consent.pdf

安大略省内科医师与外科医师管理局

https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Consent-to-Treatment

卑诗省卫生厅

https://www.health.gov.bc.ca/library/publications/year/2011/health-care-providers'-guide-to-consent-to-health-care.pdf

[3] 根据医疗（同意）与医疗照护设施（住院）法第 9.2 节，治疗同意仅适用于病患针对某种特定治疗所提供的同意。

资料来源

卑诗省中医针灸管理局 2016 年版法理学课程手册：
https://www.ctcma.bc.ca/media/1063/jurisprudence-handbook-en-web.pdf

卑诗省中医针灸管理局 2016 年版病历纪录样本表格：

https://www.ctcma.bc.ca/media/1639/clinical-record-keeping-practice-standard-sample-forms.docx

卑诗省政府医疗（同意）与医疗照护设施（住院）法第 181 章：

https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96181_01

卑诗省政府婴儿法（1996 年）第 223 章：

https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96223_01.

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有關同意治療的執業準則

卑詩省中醫針灸管理局（簡稱管理局）的執業準則確立註冊成員在提供傳統中醫治療服務前必須達到的最低專業能力水平，管理局與旗下各委員會通過執業準則、法理學課程手冊和其他相關法令，以評斷註冊學員的執業水平與專業行為。

在執業準則中，“必須”這個詞代表管理局的要求，“建議”這個詞表示管理局的期望，註冊成員可以自行運用合理判斷做決定。

定義

同意治療：病患或其代做決定者自願同意接受執業醫師建議的診斷或治療，病患或代做決定者可以隨時撤回同意。

默許的同意：通過非語言的行動所表達的同意

能力：一個人有能力瞭解與診斷或治療有關的資訊，這類資訊說明患者決定是否同意治療，所謂的能力也表示可以理解決定接受診斷與治療或決定不接受診斷與治療可能預見的後果。同意治療的能力可能隨著時間的推移而改變，此外，個別患者與特定治療決定的複雜程度也會影響做決定的能力。

未成年者：19 歲以下的人

成熟未成年者的同意：未成年者同意接受或拒絕診斷與治療，但是執業醫師必須先確定未成年患者已經瞭解診斷或治療的性質、後果，以及可以預見的風險和好處。

代做決定者：經授權替沒有做決定能力的患者來決定接受或拒絕治療

標準

執業醫師**必須**遵循以下要求來執業：

一般原則

1. 執業醫師明白並遵守醫療（同意）與醫療照護設施（住院）法(HCCCFAA)和嬰兒法中所有的要求。
2. 患者可通過三種方式同意或拒絕治療：書面、口頭或默許。

3. 執業醫師在進行診斷或治療前取得有效的同意，所謂有效同意必須有針對性，不可以根據過去取得的同意或是廣泛的同意，而是針對每一次特定的治療所做的同意決定。
4. 任何時間病患都有權利拒絕治療或撤回治療同意，執業醫師尊重病患同意治療或拒絕治療的決定。
5. 執業醫師與病患持續保持交流，在這過程中，醫師如果發現患者對診斷或治療的理解或意願有所改變，那麼就應當重新確認患者的同意。每個病患不一樣，醫師據此調整溝通方式，以確認病患明確瞭解醫師提供的資訊和說明。[1]

確認病患提供治療同意的能力

6. 執業醫師在取得病患同意時，先確定病患本人有能力做出同意決定。醫師可以假定病患有此能力，除非有合理理由認為病患沒有做出治療決定的能力（例如：病患過去的病歷或行為值得醫師懷疑病患同意治療的能力）。
7. 測試病患是否有能力做決定的第一步是確認病患是否瞭解與治療有關的資訊，病患需要具備消化與其病情和治療相關資訊的能力，尤其是理解治療所帶來的潛在好處與風險。測試病患是否有能力做決定的第二步是確認病患是否能理解決定與否的後果，不論是接受或不接受醫師的治療建議，都能理解可能預見的後果。
8. 執業醫師在不同的時間點考量病患針對特定診斷或治療建議做決定的能力。

沒有決定能力的病患與其代做決定者

9. 如果執業醫師有合理的理由認定病患本人沒有能力給與知情同意，那麼如有可能應告知病患讓一個代做決定者予以協助，以瞭解醫師建議的診斷或治療，同時讓病患知道代做決定者將替病患做最後決定。執業醫師在與代做決定者進行討論時，應當儘量讓缺乏決定能力的病患參與，至於如何選擇代做決定者，醫療（同意）與醫療照護設施（住院）法第 16 節注明了代做決定者的挑選優先次序與應有的資格。
10. 執業醫師在病患的病歷紀錄中記下代做決定者的姓名和聯繫方式。

未成年者

11. 如果未成年病患有能力給與醫師治療同意，執業醫師可直接接受該同意，無需病患的父母或監護人的同意。

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[1] 根據醫療（同意）與醫療照護設施（住院）法第八節, 執業醫師有責任以適用於病患能力和水準的方式與病患溝通。

12. 病患是否有能力做出治療同意與年齡無關，因此執業醫師在確認未成年病患是否有能力做決定時，也當將病患視為成人看待。

13. 如果未成年病患沒有能力提供治療同意，執業醫師應當取得病患父母或監護人的同意。

取得並記錄病患同意

14. 在以下的條件下病患同意才算有效：
    a. 病患直接提供醫師同意，如果病患沒有做決定的能力，其代做決定者直接提供醫師同意。
    b. 治療同意為知情同意，並且包括以下要素：[2]
        - 建議診斷或治療的性質
        - 誰來進行建議的診斷或治療
        - 建議診斷或治療的原因
        - 建議診斷或治療的潛在風險和好處
        - 可以取代建議診斷或治療的替代方案
        - 告知病患他們任何時候都有權拒絕或撤回同意
        - 不接受建議診斷或治療的後果
        - 告知病患他們有權針對建議診斷或治療提出問題，並有權獲得醫師的解答。
    c. 病患同意是出自自願，醫師不得通過脅迫、詐欺或誤導取得病患同意。
    d. 病患的同意是針對醫師建議的特定診斷或治療
    e. 執業醫師提供病患或其代做決定者討論診斷或治療同意，提供醫療（同意）與醫療照護設施（住院）法第 14(b)節所注明的資訊，並採取合理的步驟以確認病患或其代做決定者充分瞭解所提供的資訊。

15. 執業醫師在病患病歷中詳實記錄病患同意或拒絕治療，或撤回同意的細節。

16. 執業醫師進行追蹤治療時，儘管最初的治療計畫沒有變更，仍需確認原有的病患同意依然有效。如果治療計畫有變（例如：醫師將採取新的治療方式），而且新的治

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[2]. 節錄自法理學课程手冊（第 11 頁）和醫療（同意）與醫療照護設施（住院）法第六節。

療計畫不在當初的治療同意中，執業醫師需要針對特定的治療計畫變更另行取得病患同意。[3]

17. 執業醫師取得病患同意後，應在病歷中應記錄任何有關病患同意的變化與顧慮，並採取行動應對解決。（例如：病患不再有能力提供治療同意，而且已有一名經授權的代做決定者。）

18. 執業醫師如果接到未成年病患的治療同意，須在病歷中記錄該病患的決定與背後原因。

執業建議

建議執業醫師以適合病患文化背景、語言與個人偏好的方式進行溝通，例如：醫師可以使用簡單易懂、適合病患年齡的語言，或是通過翻譯人員（如果適用的話），以確定病患充分瞭解醫師所言，以便做出同意治療或撤回同意的決定。

語言障礙或溝通障礙可能阻礙病患提供有效治療同意的能力，建議執業醫師考慮這類問題，如果不確定自身與病患同意相關的法定義務，建議醫師需求獨立的法務諮詢。

病患同意最好是書面同意，同意書上應注明病患姓名，由病患簽字並注明簽字日期。同意書應與第 14(b)節明列的知情同意要素一起附在病患病歷中。

某些提供專業責任險的保險公司可能要求執業醫師在病患同意表格中注明病患可能會有的健康風險，如果沒有如是注明，保險公司可能拒絕理賠。舉例來說，進行針灸治療前，應向病患提及針灸的可能風險是氣胸。建議執業醫師仔細瞭解其專業責任險保單條款。

以上內容根據下列檔摘要改寫，謹此致謝：

卑詩省內科醫師與外科醫師管理局

https://www.cpsbc.ca/files/pdf/NHMSFAP-AS-Consent.pdf

安大略省內科醫師與外科醫師管理局

https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Consent-to-Treatment

卑詩省衛生廳

https://www.health.gov.bc.ca/library/publications/year/2011/health-care-providers'-guide-to-consent-to-health-care.pdf

[3] 根據醫療（同意）與醫療照護設施（住院）法第 9.2 節，治療同意僅適用於病患針對某種特定治療所提供的同意。

資料來源

卑詩省中醫針灸管理局 2016 年版法理學課程手冊：
https://www.ctcma.bc.ca/media/1063/jurisprudence-handbook-en-web.pdf

卑詩省中醫針灸管理局 2016 年版病歷紀錄樣本表格：

https://www.ctcma.bc.ca/media/1639/clinical-record-keeping-practice-standard-sample-forms.docx

卑詩省政府醫療（同意）與醫療照護設施（住院）法第 181 章：

https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96181_01

卑詩省政府嬰兒法（1996 年）第 223 章：

https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96223_01.