EMERGENCY CONSENT TOOLKIT FOR OBSTETRICAL AND GYNAECOLOGICAL CARE FOR HEALTH CARE PROVIDERS

IMPORTANT USAGE NOTE: This toolkit supports rapid, respectful consent conversations in emergency and high-risk obstetrical and gynaecological care. It does not replace professional judgment, local policy, applicable law, regulatory standards or legal advice. Institutions may adapt it with appropriate clinical, legal, patient safety, risk management, cultural and equity considerations before use.

About This Toolkit

Informed consent is a core component of safe, respectful, and patient-centred obstetrical and gynaecological care. In urgent, high-risk or rapidly evolving situations, consent conversations may need to happen quickly, but they must still be clear, voluntary, respectful and appropriately documented.

This toolkit supports health care providers in obtaining, confirming and documenting informed consent when obstetrical and gynaecological (OB/GYN) care is urgent, high-risk or rapidly evolving. It draws on Canadian and international clinical, legal, ethical and patient-safety guidance and is intended to support practical, trauma- and violence-informed and culturally safe consent practices without delaying time-sensitive emergency care.

This toolkit recognizes the historical and ongoing harms of forced, coerced and imposed sterilization, as well as broader obstetrical and gynaecological violence, including harms linked to systemic racism, colonialism and discrimination against Indigenous, racialized and marginalized communities. These harms underscore the need for consent processes that protect patient autonomy, support clear communication and include additional safeguards where procedures may permanently prevent reproduction.

It is designed as a point-of-care and implementation resource for rapid consent conversations, documentation, team communication and post-event follow-up. It should be used alongside professional judgment, local policy, applicable law, regulatory standards and institutional requirements.

The sections that follow provide core principles, practical checklists, communication prompts, documentation tools and team-based practices that can be adapted for local implementation.

Toolkit Contents at-a-Glance

Core Principles of Emergency and High-Risk Consent

The following principles guide consent conversations, documentation and team communication in urgent, high-risk or rapidly evolving obstetrical and gynaecological care.

Consent is a process, not a signature.

Consent is procedure-specific and must be based on the patient's understanding of the proposed intervention. Valid consent requires capacity, clear disclosure of the nature of the intervention, expected benefits, material risks and reasonable alternatives, and voluntary agreement that is free from coercion, pressure, misrepresentation or omission of material information. A patient may refuse, delay or withdraw consent.

Pain, labour, fear or distress do not automatically remove capacity.

These circumstances may affect communication, understanding or voluntariness, but they do not automatically mean the patient lacks capacity. Assess whether the patient can understand the situation, appreciate the consequences and communicate a decision. Use plain language, repeat key information where needed and confirm understanding.

Consent must be voluntary, active and free from coercion.

Silence, compliance or lack of objection is not consent. Clinicians should be alert to pressure from any source, including fear-based urgency, repeated persuasion, threats, assumptions, power imbalance, incomplete disclosure or pressure from partners, family members, support people or members of the care team. Where the patient hesitates, appears overwhelmed or says "just do it" while distressed, reassess understanding and voluntariness where clinically possible.

Informed refusal and withdrawal are part of the consent process.

A patient with capacity may refuse, delay or withdraw consent, even when care is urgent. Clinicians should explore concerns, explain the risks of declining or delaying care, identify reasonable alternatives where available and document the discussion and revised plan. Refusal or withdrawal must not be met with coercion, threats, repeated pressure or shame.

Consent should be sought unless delay would create an imminent risk to the patient's life or health.

Urgency does not remove the requirement to seek consent when the patient has capacity and can participate in decision-making. Treatment without prior consent is limited to circumstances where immediate action is necessary to protect the patient's life or health and consent cannot be obtained without unsafe delay. Fetal status may create clinical urgency, but it does not, on its own, remove the requirement to seek consent from the pregnant or birthing patient whenever they can participate.

Emergency treatment without prior consent must be narrow and time-limited.

Treatment without prior consent may be appropriate only when immediate action is necessary to protect the patient's life or health and consent cannot be obtained without unsafe delay. Treatment should be limited to what is necessary to address the immediate risk, with the consent conversation resumed as soon as it is safe to do so.

Fetal indications may create urgency, but they do not replace the patient's consent.

Fetal status may be part of the clinical information discussed with the patient and may create urgent or rapidly evolving circumstances. It does not remove the requirement to seek the pregnant or birthing patient's consent whenever the patient can participate. Communication and documentation should remain grounded in the patient's capacity, consent, clinical condition and life or health needs.

Consent should be trauma- and violence-informed and culturally safe.

Patients may have experienced trauma, violence, racism, discrimination, colonial harm or previous medical harm that affects trust, communication and consent. Explain before touching, offer choices where possible, use qualified interpreters when needed and support patient-identified cultural, family, community or advocacy supports where appropriate.

Procedures that may permanently prevent reproduction require additional safeguards.

Where a procedure may permanently prevent reproduction or affect future fertility, this impact must be stated clearly. The patient should understand why the intervention is being recommended, whether any reasonable, less fertility-impacting alternatives exist and whether delay would create unacceptable risk. These procedures require particular care, clear communication, careful documentation and additional safeguards wherever possible.

Documentation must be clear, timely and proportionate to the risk.

Record the urgency, capacity assessment, information provided, patient questions, consent decision, refusal or withdrawal, interpreter or support person involvement and any fertility or reproductive implications. If treatment proceeds without prior consent, document why consent could not be obtained without unsafe delay, what alternatives were considered, what treatment was provided and when communication resumed.

Emergency Consent Pathway

This pathway supports clinicians in matching the consent approach to the level of clinical urgency. Urgent, high-risk or rapidly evolving care does not, on its own, create an emergency exception to consent. When the patient has capacity and can participate in decision-making, the consent process should be followed, with the amount of detail and time adjusted to the clinical situation. Treatment without prior consent is limited to immediate emergencies where consent cannot be obtained without unsafe delay, and action is necessary to protect the patient's life or health or prevent serious harm.

Use the pathway in sequence: first identify the level of urgency, then assess capacity, identify any reproductive or fertility impact, obtain consent where possible, document the decision-making process and follow up after the event.

STEP 1: Identify the level of urgency

The level of urgency determines how much information can reasonably be provided before treatment, but it does not remove the need to communicate as clearly as the situation allows.

Situation	Consent Approach
Urgent but stable	Use a focused, informed consent discussion. Explain the situation, recommendation, key risks, alternatives and ask for agreement.
Rapidly escalating	Use rapid consent. Provide the clearest explanation possible in the time available and ask for agreement before proceeding.
Immediate threat to life *and* consent cannot be obtained	Provide necessary emergency treatment without delaying care. Continue communication as soon as possible and document why immediate treatment was required.

Before moving to the next step, confirm:

- Can the patient participate in the decision?
- Is there time to provide a focused or rapid consent discussion?
- Are there reproductive or fertility implications?
- What needs to be documented?

Quick Rule: Move as quickly as the emergency requires but communicate as clearly as the situation allows.

STEP 2: Assess capacity

Capacity is the ability to understand information, appreciate the consequences of a decision and communicate a choice. Pain, labour, fear or distress require enhanced assessment, not an assumption of incapacity. Use plain language and assess whether the patient can understand the situation, weigh the risks and consequences and make a decision.

Where possible:

- Explain what is happening.
- Ask what the patient understands.
- Invite questions.
- Use an interpreter when needed.
- Confirm the patient's decision is voluntary and free from pressure.

If a qualified interpreter is needed but not immediately available, continue efforts to obtain one. If care cannot safely wait, use plain language, short statements and visual cues where appropriate, and confirm understanding. Avoid relying on family, partners or untrained staff where privacy, accuracy, coercion or safety may be a concern. Revisit the discussion with a qualified interpreter as soon as feasible.

Consent for sterilization or procedures that may permanently prevent reproduction should not be initiated for the first time during labour, acute distress, sedation, impaired cognition, on the operating table, while the patient is positioned or restrained for surgery, or after the procedure has already been performed, unless a true emergency exists and the procedure is immediately necessary to protect the patient's life or health.

Where there has been prior discussion or consent for a procedure that may permanently prevent reproduction or affect future fertility, confirm where that documentation is located, whether it is available to the treating team and whether the patient still wishes to proceed in the current clinical context. Local protocols should identify where prior consent discussions and consent documentation are recorded and how they are made visible to the team during urgent or unplanned care.

Involve a substitute decision-maker only when the patient lacks capacity and doing so will not create an unsafe delay. Where appropriate and consistent with applicable law, privacy requirements and the patient's known wishes, notify or involve the patient-identified contact, family member or support person as soon as feasible.

Additional safeguard for sterilization or procedures that may permanently prevent reproduction: Substitute decision-making cannot be used to authorize sterilization unless the procedure is immediately necessary to save the patient's life or prevent serious harm, and no reasonable alternative exists.

Section 45 of the Criminal Code addresses criminal responsibility protection for surgical operations performed for a patient's benefit, with reasonable care and skill, and where reasonable in the circumstances. It does not replace consent requirements or applicable substitute decision-making law. If treatment proceeds without prior consent, document the urgency, rationale, alternatives considered, communication efforts and post-event explanation.

STEP 3: Identify reproductive or fertility impact and apply safeguards

This step determines whether additional safeguards are required before proceeding to the consent discussion in **Step 4**, or before any procedure with permanent reproductive impact proceeds in a true emergency where the patient cannot participate.

If the recommended intervention may permanently prevent reproduction or otherwise affect future fertility, state this clearly as soon as clinically possible. Examples may include tubal ligation, hysterectomy, salpingectomy, oophorectomy, endometrial ablation, uterine artery embolization or another procedure with significant reproductive or fertility implications.

If no reproductive or fertility impact is identified, proceed to **Step 4**.

Where reproductive or fertility impact is identified, additional safeguards apply. Before proceeding, identify:

- The reproductive or fertility impact, including whether it may be permanent.
- The material risks and possible complications of the proposed intervention, proportionate to the urgency of the situation.
- Why the intervention is being recommended or performed.
- Whether any reasonable, less fertility-impacting alternatives exist.
- The risks of delaying or declining the recommended intervention.

Avoid vague or informal language such as "tie your tubes," "clip," "unclip," "fix this," or "make sure this does not happen again." Clearly name the proposed procedure, explain whether it is intended to be permanent, describe any uncertainty about reversibility and confirm that the patient understands the reproductive or fertility impact.

For procedures that may permanently prevent reproduction or have significant fertility implications, consent must be:

- Clearly given for the specific procedure, verbally or in writing, where consent can be obtained.
- Provided by the patient, except in the narrow emergency circumstances (see below).
- Based on a clear understanding of the reproductive or fertility impact.
- Free from coercion, pressure, misrepresentation, omission of material information or situational vulnerability.

If the patient can participate in the consent discussion and decision-making, proceed to **Step 4**.

If the patient cannot participate and consent cannot be obtained without delay that would create an immediate threat to the patient's life or health, or a risk of serious harm:

A procedure that may permanently prevent reproduction must not proceed unless all of the following criteria are met:

- There is an immediate threat to the patient's life or health, or a risk of serious harm.
- The procedure is necessary to address that threat.
- No reasonable, less fertility-impacting alternative exists.
- Delay to obtain consent would create unacceptable risk.

If any criterion is not met, do not proceed with sterilization or another procedure that may permanently prevent reproduction.

If all criteria are met, proceed only to the extent strictly necessary to address the immediate threat. Resume communication when possible and fully document the clinical justification.

Where feasible and without creating unsafe delay, seek input from a second clinician before proceeding with a procedure that may permanently prevent reproduction without prior consent. If a second clinician is not available, this should not delay necessary emergency care. Document the clinicians involved, the emergency criteria considered, any alternatives discussed and the rationale for proceeding.

Sterilization or another procedure that may permanently prevent reproduction must not proceed without valid, specific consent when:

- The procedure is proposed for convenience, efficiency, anticipated future risk or future pregnancy prevention, rather than being immediately necessary to address the current emergency.
- Consent is initiated for the first time during labour, acute distress, sedation or impaired cognition, unless a true emergency exists and the procedure is immediately necessary to protect the patient's life or health.
- A substitute decision-maker is used outside the narrow emergency criteria above.
- A reasonable, less fertility-impacting alternative exists.

STEP 4: Obtain or confirm consent where possible

When the patient can participate in the consent discussion, use the information gathered in Steps 1 to 3 to guide the consent conversation. The discussion should be proportionate to the urgency of the situation and should include the essential information needed for the patient to make an informed decision.

Where the patient has capacity and needs clarification, the consent discussion may take time; where clinically possible, a brief delay to answer questions or confirm understanding may be necessary to support valid consent.

Clearly state:

- The clinical condition.
- The level of urgency.
- The recommended treatment.
- Risks, expected benefits and reasonable alternatives, including no treatment if applicable.
- Any reproductive or fertility impact, where relevant.
- The risks of delaying or declining care.

Confirm:

- The patient's understanding.
- The opportunity for questions.
- Voluntary agreement, refusal, delay or withdrawal of consent.
- Any interpreter, support person or accommodation needed to support understanding.

Where the patient hesitates, refuses, delays or withdraws consent, explore concerns respectfully, explain the risks of declining or delaying care, identify reasonable alternatives where available and revise the care plan as clinically appropriate.

STEP 5: Document the consent process and clinical rationale

Documentation must be clear, timely and proportionate to the urgency, risk and potential impact of the intervention. It should support the clinical and consent basis for the decision, including consent, refusal, delay, withdrawal or emergency treatment without prior consent.

At minimum, document:

- The clinical condition and level of urgency.
- The capacity assessment, including any factors affecting communication or understanding.
- The information provided to the patient, including key risks, expected benefits and reasonable alternatives.
- Patient questions, concerns and responses.
- The consent decision, including consent, refusal, delay or withdrawal.
- Use of an interpreter, support person, accessibility accommodation or substitute decision-maker, where applicable.
- Any follow-up explanation or reassessment required.

For procedures that may permanently prevent reproduction or have significant fertility implications, also document:

- The reproductive or fertility impact discussed, where possible.
- Why the procedure was clinically necessary.
- Any reasonable, less fertility-impacting alternatives considered and why they were not appropriate or available.
- Why delay would have created unacceptable risk, where applicable.
- Why prior consent could not be obtained without unsafe delay, where applicable.
- Efforts made to communicate before, during or after treatment.
- Names and roles of involved clinicians.

If a procedure that may permanently prevent reproduction proceeds without prior consent, documentation should clearly address each emergency criterion:

- "Immediate threat identified: _____ "
- "Procedure required to address threat because: _____ "
- "Reproductive/fertility impact: _____ "
- "Alternatives considered: _____ "
- "Reason alternatives were not appropriate or available: _____ "
- "Reason prior consent could not be obtained without unsafe delay: _____ "
- "Communication attempted: _____ "
- "Post-emergency explanation provided: _____ "
- "Clinicians involved: _____ "

Proceed to **Step 6** for post-event discussion and follow-up.

STEP 6: Post-event discussion and disclosure

As soon as the patient is stable and it is clinically appropriate, resume the consent conversation and provide a clear post-event explanation. This discussion should be timely, respectful and documented.

Explain:

- What happened.
- What treatment was provided.
- Why urgent or emergency action was needed.
- Whether prior consent was obtained, limited or could not be obtained before treatment.
- Any reproductive or fertility implications, where relevant.
- What follow-up care is needed.
- Who the patient can speak to with questions or concerns.

Where applicable, offer:

- Time for questions and clarification.
- Emotional support.
- Reproductive counselling or referral.
- Cultural, spiritual, patient navigation or advocacy supports, where available and desired by the patient.
- Follow-up with the responsible clinician or care team.

If emergency treatment proceeded without prior consent, explain why the decision was made, why delay would have created unsafe risk and what steps were taken to limit treatment to what was necessary to address the immediate threat.

Where the intervention has reproductive, fertility or sexual health implications, offer follow-up that addresses physical, hormonal, reproductive, sexual, emotional and cultural support needs, with referral to appropriate services where available and desired by the patient.

Document the post-event discussion, including the explanation provided, patient questions or concerns, supports offered, follow-up plan and any further disclosure or review required.

CLEAR Communication Model

A communication framework for explaining urgent care clearly, checking understanding and asking for agreement without coercion.

Step	What To Do	Example Language
Context	State what is happening.	"Your bleeding is heavier than expected."
Limits	Explain why time is limited.	"We need to act quickly to keep you safe."
Explain	Give the recommendation, key risks and alternatives where possible.	"I recommend medication now. If it does not work, we may need a procedure."
Ask	Check understanding, invite questions and ask for agreement.	"What questions do you have? Can you tell me what you understand? Is it okay to proceed?"
Respect	Respect consent, refusal, delay or withdrawal. Avoid pressure and document the discussion.	"I hear your concern. Let's talk through the risks of waiting and what other options may be available."

In cases where reproduction or fertility may be impacted, clearly communicate:

"This treatment may permanently affect your ability to become pregnant in the future. I want to make sure you understand that before we proceed."

Quick Rule: Be brief, clear and direct. Avoid pressure, blame and fear-based language.

Trauma- and Violence-Informed and Culturally Safe Consent Practices

These practices support patient dignity, autonomy, trust and cultural safety during urgent or high-risk care. They are especially important in obstetrical and gynaecological care given the historical and ongoing harms of forced and coerced sterilization, reproductive coercion, racism, colonial harm and discrimination in health care.

Patients may have experienced trauma, violence, racism, discrimination, colonial harm or previous medical harm that affects trust, communication and consent. The practices below support trauma- and violence-informed and culturally safe consent by helping clinicians recognize power imbalances, communicate clearly, avoid coercion and support access to interpreters, advocates, family or other supports where appropriate.

In emergency care, clinicians may need to move quickly. Speed should not become pressure. Where time allows, consent conversations should remain patient-led, clear, respectful and free from coercion. The patient should remain the final decision-maker whenever they can participate in the consent discussion and decision-making.

Recognize power imbalance.

A patient may feel pressure to agree because of urgency, the number of people in the room, past experiences of harm or the authority of the clinical team.

Example language: "You are the decision-maker. My role is to explain what is happening, what I recommend and what the risks and options are."

Be mindful of bias and assumptions.

Assumptions about a patient (e.g., age, gender, number of children, substance use, parenting ability, pain tolerance, socioeconomic status, race, culture or family circumstances) must not shape the consent discussion, pain management, recommended options or urgency of the proposed intervention.

Explain before touching or examining.

Even in urgent care, explain what you need to do and why before an exam, procedure or transfer, unless immediate action is required to prevent serious harm.

Example language: "I need to check [body part/procedure] because [reason]. Is it okay if I do that now?"

Use micro-consent throughout care to minimize obstetrical and gynaecological violence.

Consent is ongoing. Use short check-ins before each step, especially when care is painful, intimate, invasive or rapidly changing.

Example language: "I'm going to do the next step now. Is it okay to continue?"

Avoid pressure, fear-based urgency or repeated persuasion.

Explain the seriousness of the situation without using threats, shame or language that makes the patient feel they have no choice.

Example language: "This is urgent, and I want to explain the risk of waiting. I also want to understand your concerns."

Check understanding, not just agreement.

A quick "yes" may not mean the patient understands. Ask the patient to describe what they understand where time allows.

Example language: "Can you tell me what you understand about what is happening and what we are recommending?"

Support language access.

Use a qualified interpreter whenever possible. If a qualified interpreter is not immediately available and delaying care would create unsafe risk, use the clearest available communication support, plain language, visual cues or translation tools where appropriate, while continuing efforts to obtain qualified interpretation. Avoid relying on family, partners or staff to interpret when privacy, accuracy, coercion or safety may be a concern. Revisit the discussion with a qualified interpreter as soon as possible.

Example language: "We are getting an interpreter so this can be explained clearly. I will keep using plain language while we wait."

Invite support without transferring decision-making.

Ask the patient who they want present and, where clinically possible, speak with the patient briefly in private to confirm their preferences, understanding, voluntariness and safety. Support people may assist but should not answer for or pressure the patient unless legally authorized. If coercion is suspected, pause where safe and follow local family violence, intimate partner violence or safety protocols.

Brief prompts may include: "Who would you like present for this discussion?" "What role would you like them to have?" "Are you comfortable with this interpreter or support person being involved?" "Would you like anyone to step out?" "Do you feel comfortable moving forward?"

Make space for refusal, hesitation or a pause where safe.

Hesitation can signal distress, confusion, fear, coercion or a need for more information. Pause where clinically possible and clarify concerns.

Example language: "I hear that you are unsure. We can pause for a moment. What worries you most right now?"

Watch for Consent Breakdown

Pause or reassess where clinically possible if the patient is:

- Silent, frozen, overwhelmed or visibly distressed.
- Saying "just do it" while overwhelmed.
- Not responding to questions or appearing unable to process information.
- Looking to a partner, family member or staff member to answer for them.
- Relying on a family member, partner or staff member to interpret when a qualified interpreter is needed.
- Appearing pressured by a partner, family member, clinician or team dynamic.
- Agreeing after repeated requests, escalating language or fear-based explanations.

Related Guidance

For more detailed guidance on culturally safe, patient-led consent conversations with First Nations patients, health care providers are encouraged to review the First Nations Health Authority's *Coercion and Consent: A Health Care Provider's Guide for Facilitating Consent Conversations with First Nations Patients.*

Quick Rule: Move quickly when the emergency requires it, but do not let urgency become coercion. Explain what is happening, preserve choice where possible, check understanding and continue communication throughout care.

High-Risk Scenarios and Scripts

The following scripts provide adaptable point-of-care language for common emergency and high-risk obstetrical and gynaecological situations. They are prompts, not fixed wording. Clinicians should adapt the language to the clinical situation, level of urgency, patient needs and time available.

Where possible, use the CLEAR model: state what is happening, explain why time is limited, provide the recommendation, check understanding and ask for agreement. Continue communication during care and revisit the consent conversation after the emergency where needed.

Where clinically possible, close each script by asking: "What questions do you have? Can you tell me what you understand about why we are recommending this? Is it okay to proceed?"

A. Emergency Caesarean Birth

"Your baby is showing signs of distress, and we are concerned about their safety. I recommend an urgent caesarean birth because this is the fastest way to deliver your baby. The main risks include bleeding, infection and injury to nearby organs. Waiting may increase risk."

B. Operative Vaginal Birth

"Your baby needs to be delivered soon. One option is to assist the birth with forceps or vacuum. Another option may be caesarean birth, depending on the situation. I recommend [option] because of [reason]. The main risks include tearing, bleeding and possible injury to the baby."

C. Postpartum Hemorrhage

"You are bleeding more than expected, and we need to act quickly to keep you safe. We are starting with [medication/procedure]. If that does not work, we may need additional steps. I will explain what we are doing as we go."

D. Emergency Hysterectomy or Fertility-Impacting Procedure

"The bleeding is life-threatening, and the treatments we have tried are not enough. A hysterectomy may be needed to save your life. This would mean you could not become pregnant in the future. We will avoid any fertility-impacting procedure that is not medically necessary."

E. Ectopic Pregnancy / Possible Salpingectomy, Oophorectomy or Cornual Resection

"The pregnancy is outside the uterus and cannot continue safely. This can become dangerous because it may rupture and cause serious internal bleeding. I recommend [medication/surgery] because [reason]. This treatment will end the ectopic pregnancy. Surgery may involve removing the affected fallopian tube if it cannot be safely preserved. If the ovary or the part of the uterus where the pregnancy is attached is involved, surgery may also involve removing the ovary or part of the uterus. These procedures may affect future fertility or future pregnancy, and I want to be clear about that before we proceed."

F. Ovarian Torsion / Possible Oophorectomy

"The ovary may be twisted, which can cut off its blood supply. We recommend surgery to try to untwist and preserve it. Removal may become necessary if it cannot be safely preserved. Removing an ovary may reduce ovarian reserve and may affect future fertility. We will preserve the ovary if it is safe to do so."

G. Urgent Uterine Evacuation

"There is tissue or bleeding that needs urgent treatment. I recommend [medication/procedure] because [reason]. If there is an ongoing pregnancy, this treatment will end the pregnancy, and I want to be clear about that before we proceed. The main risks include bleeding, infection, injury to the uterus, needing another treatment and scar tissue inside the uterus that may affect future fertility. What questions do you have? Is it okay to proceed?"

H. Patient Hesitation, Refusal, Delay or Withdrawal

"I hear that you are unsure. This is serious, and waiting may increase risk. I want to understand what worries you most and make sure you have the information you need. You have the right to make this decision."

I. Language Barrier or Interpreter Delay

"We need to explain this clearly. We are getting an interpreter now. If we need to act before the interpreter is available because this is an emergency, we will use the clearest communication possible and explain everything again as soon as we can."

Quick Rule: Labour and delivery consent is ongoing.

Use brief check-ins throughout care:

- **Before:** "I recommend [exam/procedure] because [reason]. Is it okay to proceed?"
- **During:** "You may feel pressure. I will explain each step. Tell me if you need me to pause."
- **After:** "Here is what we found, what we did and what it means."

Additional Consent Considerations

The following considerations may require additional attention during urgent, high-risk or rapidly evolving care. They should be applied alongside the core principles, emergency consent pathway and documentation prompts above.

A. Patient May Lack Capacity

Do not assume incapacity because the patient is in pain, in labour, afraid or distressed. Assess whether the patient can understand the situation and risks and make a decision.

If the patient lacks capacity:

- Involve a substitute decision-maker where available and where doing so will not create an unsafe delay.
- Provide necessary emergency treatment if immediate action is required.
- Document the capacity concern, urgency, decision-maker involvement and reason for proceeding.

B. Language Barriers

Use a qualified interpreter whenever possible, even briefly. Ask about the patient's preferred language and whether they want a qualified interpreter, medical escort or other communication support involved, where this can be done without unsafe delay.

If time is limited:

- Use plain language.
- Avoid medical jargon.
- Confirm understanding.
- Avoid relying on a partner or family member to interpret when there are concerns about privacy, coercion or safety.

C. Cultural Safety and Support Needs

Do not assume what supports a patient needs or who they want involved in care. Where time allows, ask about cultural, spiritual, religious, family, community or advocacy supports that may help the patient feel informed and safe. Cultural or religious considerations related to pregnancy, pregnancy loss, birth, fertility, sterilization or reproductive decision-making should be explored respectfully, without assumptions and without allowing others' views to override the patient's own consent.

Where appropriate:

- Ask who the patient wants involved in the conversation.
- Support access to an Indigenous patient navigator, advocate, Elder, cultural support person or other support where available.
- Respect the patient's preferences about family or community involvement.
- Avoid relying on family members to speak for the patient unless the patient wants this and it is appropriate.
- Document any supports offered, requested or used.

D. Gender Identity, Pronouns and Anatomy-Specific Care

Do not assume a patient's gender identity, pronouns, anatomy, reproductive goals or support needs. Use the patient's affirmed name and pronouns and explain why anatomy-specific or pregnancy-related questions are being asked when they are clinically relevant. Respect the privacy wishes of the patient.

E. Refusal or Withdrawal of Consent

A patient with capacity may refuse, delay or withdraw consent, even when the recommended care is urgent. Refusal, hesitation or withdrawal of consent should be explored respectfully and without coercion, threats, shame or repeated pressure.

Use language such as: "I respect your decision. I want to make sure you understand the risks and options. Can we talk through what concerns you most?"

Document the discussion, risks reviewed, questions answered and revised care plan.

F. Adolescents

The term "adolescent" generally refers to patients aged 10 to 19 years. There may be specific legal, regulatory or institutional requirements when providing care to adolescents. Assess capacity and follow applicable provincial or territorial consent requirements. Do not assume that age alone determines capacity.

Where appropriate:

- Speak with the adolescent privately.
- Confirm understanding and voluntariness.
- Involve parents, guardians or substitute decision-makers where required or appropriate, with attention to the patient's wishes and safety.

Documentation Tools and Prompts

Documentation should clearly reflect the clinical situation, the consent discussion, the patient's decision and the rationale for any emergency treatment provided without prior consent. The prompts below can be adapted for urgent, rapidly evolving or emergency care.

Where applicable, document:

- The clinical issue and level of urgency.
- The information provided, including key risks, benefits and reasonable alternatives.
- Patient questions, concerns, hesitation, consent, refusal or withdrawal.
- Use of an interpreter, support person or substitute decision-maker.
- Any reproductive or fertility implications discussed.
- Why immediate treatment was necessary if prior consent could not be obtained.
- Any follow-up explanation provided after the emergency.

A. Rapid Consent Documentation Prompt

"Discussed [clinical concern] and recommendation for [intervention]. Explained urgency, expected benefit, key risks and reasonable alternatives in the time available. Patient had opportunity to ask questions and provided verbal consent. Ongoing updates provided during care."

B. Refusal or Withdrawal Documentation Prompt

"Discussed recommendation for [intervention], including urgency, risks of proceeding and risks of delay or refusal. Patient expressed concern about [concern]. Questions answered. Patient [declined/requested more time/withdrew consent]. Plan revised to [plan], with ongoing monitoring and reassessment."

C. Emergency Treatment Without Prior Consent Documentation Prompt

"Immediate treatment was required due to [clinical emergency/imminent risk]. Prior consent could not be obtained because [reason]. Delay would have posed a risk of [harm]. Proceeded with [intervention] as clinically necessary. Patient/substitute decision-maker updated as soon as feasible."

Team-Based Consent Practices

In urgent or high-risk care, multiple clinicians may be involved at once. Clear team roles help maintain patient communication, support informed decision-making and ensure that consent, refusal, withdrawal or emergency treatment without prior consent is documented appropriately.

Team roles during urgent care:

- **Most responsible physician/proceduralist:** explains the recommended intervention, expected benefits, material risks, reasonable alternatives and any reproductive or fertility implications, where relevant, and obtains or confirms consent whenever clinically possible.
- **Patient communication lead:** stays with the patient, explains what is happening and checks for questions or distress.
- **Interpreter or language support:** supports clear communication when language barriers are present.
- **Documentation lead:** records the consent discussion, urgency, questions, refusal, withdrawal or reason prior consent could not be obtained.

Where care is transferred or a patient is referred for obstetrical or gynaecological assessment, the referring health care provider should, where possible, prepare the patient for the nature of the assessment, including that an intimate or pelvic examination may be recommended. Known trauma-related needs, communication needs, safety concerns or supports requested by the patient should be communicated to the receiving team in accordance with the patient's wishes and applicable privacy requirements.

Team huddle prompts:

Before proceeding, confirm:

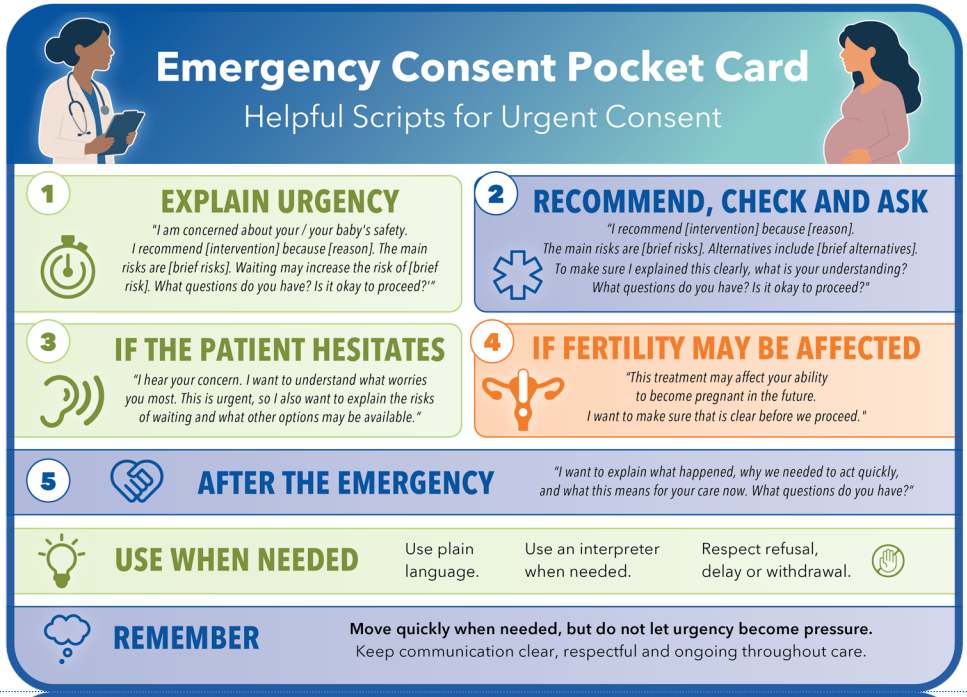
- What is the clinical urgency?
- Can the patient participate in the consent discussion and decision-making?
- What intervention is being recommended?
- Are there reproductive or fertility implications?
- Who is speaking with the patient?
- What needs to be documented?

Quick Rule: Assign the communicator.

In urgent care, one clinician should be assigned to communicate with the patient in real time, while the most responsible physician, attending physician or responsible proceduralist remains accountable for procedure-specific consent whenever clinically possible.

APPENDIX 1: Emergency Consent Pocket Card

Print, cut and fold for a two-sided point-of-care pocket card.



APPENDIX 2: Emergency Consent Checklist

Printable implementation and documentation checklist

Use: This checklist supports rapid consent conversations and documentation without delaying necessary emergency care.

1. Assess Urgency, Capacity and Communication Needs

Urgency and capacity:

- ☐ Identify the clinical concern.
- ☐ Determine whether care is urgent, rapidly escalating or immediately necessary to prevent serious harm.
- ☐ Identify whether there is an immediate threat to the patient's life or health.
- ☐ Assess whether the patient can participate in the consent discussion and decision-making.
- ☐ Assess whether the patient can understand information, appreciate consequences and communicate a decision.
- ☐ Identify whether an interpreter, support person or accessibility accommodation is needed.

Urgency level:

- ☐ Urgent but stable
- ☐ Rapidly escalating
- ☐ Immediate emergency where consent cannot be obtained without unsafe delay

Reminder: Pain, labour, fear or distress do not automatically remove capacity. Use plain language, repeat key information where needed and confirm understanding.

2. Communicate Clearly and Confirm the Decision

As time allows, explain:

- ☐ What is happening.
- ☐ Why action is needed now.
- ☐ The recommended intervention.
- ☐ Key risks and expected benefits.
- ☐ Reasonable alternatives, including no treatment where applicable.
- ☐ The risks of delaying or declining care.
- ☐ Any reproductive or fertility impact, where relevant.

Ask:

- ☐ "What questions do you have?"
- ☐ "Can you tell me what you understand?"
- ☐ "Is it okay to proceed?"

Confirm:

- ☐ Voluntary agreement.
- ☐ Refusal, delay or withdrawal of consent, where applicable.
- ☐ That the patient is not being pressured or coerced.

Reminder: Silence, compliance or lack of objection is not consent.

3. Respond to Hesitation, Refusal or Consent Breakdown

Pause or reassess where clinically possible if the patient is:

- ☐ Silent, frozen, overwhelmed or visibly distressed.
- ☐ Saying "just do it" while overwhelmed.
- ☐ Not responding to questions or appearing unable to process information.
- ☐ Looking to a partner, family member or staff member to answer for them.
- ☐ Relying on a family member, partner or staff member to interpret when a qualified interpreter is needed.
- ☐ Appearing pressured by a partner, family member, clinician or team dynamic.
- ☐ Agreeing after repeated requests, escalating language or fear-based explanations.

If the patient hesitates, refuses, delays or withdraws consent:

- ☐ Explore the patient's concerns.
- ☐ Explain the risks of declining, delaying or stopping care.
- ☐ Identify reasonable alternatives or temporizing measures where available.
- ☐ Avoid coercion, threats, shame, repeated pressure or fear-based language.

4. Apply Additional Safeguards for Reproductive or Fertility Impact

Examples may include tubal ligation, hysterectomy, salpingectomy, oophorectomy, endometrial ablation or another procedure with significant reproductive or fertility implications.

- ☐ Identify whether the intervention may permanently prevent reproduction or otherwise affect future fertility.

If impact is possible, confirm where clinically possible:

- ☐ The reproductive or fertility impact has been clearly explained.
- ☐ The patient understands whether the impact may be permanent.
- ☐ The intervention is necessary in the current clinical context.
- ☐ Reasonable, less fertility-impacting alternatives have been considered.
- ☐ The risks of delaying or declining care have been explained.

If consent cannot be obtained without unsafe delay, all must be met:

- ☐ There is an immediate threat to the patient's life or health, or a risk of serious harm.
- ☐ The procedure is necessary to address that threat.
- ☐ No reasonable, less fertility-impacting alternative exists.
- ☐ Delay to obtain consent would create unacceptable risk.

If any criterion is not met, do not proceed with any procedure that may permanently prevent reproduction.

5. Document and Follow Up

Document:

- ☐ Clinical condition and level of urgency.
- ☐ Capacity assessment.
- ☐ Information provided to the patient.
- ☐ Patient questions, concerns and responses.
- ☐ Consent, refusal, delay or withdrawal.
- ☐ Interpreter, support person, accessibility accommodation or substitute decision-maker involvement, where applicable.
- ☐ Any reproductive or fertility implications discussed.
- ☐ Alternatives considered, where applicable.
- ☐ Reason consent could not be obtained without unsafe delay, where applicable.
- ☐ Follow-up explanation provided after emergency care.

As soon as the patient is stable and clinically appropriate, explain:

- ☐ What happened.
- ☐ What treatment was provided.
- ☐ Why urgent or emergency action was needed.
- ☐ Whether prior consent was obtained, limited or could not be obtained before treatment.
- ☐ Any reproductive or fertility implications, where relevant.
- ☐ Follow-up care and next steps.
- ☐ Who the patient can speak to with questions or concerns.

Where applicable offer:

- ☐ Time for questions and clarification.
- ☐ Emotional support.
- ☐ Reproductive counselling or referral.
- ☐ Cultural, spiritual, patient navigation or advocacy supports, where available and desired by the patient.

Optional Local Notes

QUICK RULE

Move as quickly as the emergency requires but communicate as clearly as the situation allows.