Every person, including those under protective supervision or a mandate, is presumed to be capable of consenting to care. If there is any doubt:

"The patient's capacity to consent to care should be checked whenever care is proposed and during each "medical" decision requiring their consent."

The disclosure process can take place over several visits and include a discussion regarding:

- Expectations, with the professional attempting to reassure the patient and caregiver, insofar as possible, and offering realistic hope;
- The available treatment options, pharmacological and nonpharmacological (see GUO Tx MA);
- A reminder of the importance of preparing or updating the different legal documents (advance medical directives [AMDS], will and mandate in case of incapacity)*;
- The determination of the levels of care*;
- Driving-related issues and the possibility of the Société de l’assurance automobile (SAAQ*) revoking the patient’s driver’s license;
- The objectives of maintaining the patient's autonomy, and safety at home*;
- Capacity-related issues (the ability to manage their affairs, take care of themselves and consent to health care) and the determination of incapacity*; and
- The possible aids offered by the health and social services network and the existence of associations that can provide services to the patient and of caregiver support groups.

* For further information, see iness.qc.ca.

A patient’s inability to consent to care is temporary or permanent, depending on the nature of their medical condition. Regardless of their capacity to consent to care, the patient is the first person to receive the information.

The disclosure should be made with compassion and sensitivity, using an empathetic approach centred on the patient that respects their integrity.

The diagnosis should be communicated clearly by the physician in terms that the patient can understand (e.g., “memory illness”). After giving the patient and their family members the information, it should be checked that they understand it.

For health and social services professionals

The assessment of a patient’s capacity to consent to care does not look at the nature of the decision, but rather at the process, that is, the patient’s ability to:

- Understand, process or make sense of the information;
- Express a choice* and adhere to it consistently over time.

* This choice can be expressed in different ways (orally, in writing and non-orally with pictographic and gestural support) to accommodate the language skills of any patient.

For health and social services professionals

- The disclosure process can take place over several visits, depending on the circumstances.
- Once the diagnosis has been made, it should be communicated to the patient, the caregiver, the care team, if it is not present during the disclosure, and then to the other health professionals who contributed to making the diagnosis, in line with the wishes expressed by the patient and with their consent.
- The disclosure should be made with compassion and sensitivity, using an empathetic approach centred on the patient that respects their integrity.
- The diagnosis should be communicated clearly by the physician in terms that the patient can understand (e.g., “memory illness”). After giving the patient and their family members the information, it should be checked that they understand it.
The patient can be referred to specialized services or a memory clinic if they want a second opinion about their diagnosis or treatment plan.

If the patient expresses an interest in participating in diagnostic or therapeutic research, they can be given the necessary contact information for the organizations concerned.

Always be on the lookout for signs of exhaustion and physical and cognitive deterioration in the caregiver, which can occur at any stage of the disease. If necessary, you should:

- Refer the caregiver to their family physician or the appropriate local help services that provide support or respite to this type of clientele, such as the Alzheimer Society, L’Appui, Baluchon Alzheimer, home support services, a day centre, Carpe Diem or aidants.ca.;
- Give them supportive literature;
- Assess, using tools such as the Zarit scale*, the burden of looking after a patient diagnosed with an NCD who lives at home.

* The Zarit scale is mentioned as an example only, since INESSS has not done an in-depth analysis of this instrument as part of this project.