Practice Scenario - February 2016 (updated from résumé Winter 2013, "Consent Basics")

# An RD's Responsibilities Related to Consent

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A Registered Dietitian (RD) works in a hospital unit with clients who have varying mental health issues, including dementia and psychosis. Recently, the RD was consulted to recommend a tube feeding regimen for an 85 year old male client with dementia who recently had a G-tube inserted.

What are the RD's responsibilities related to consent to treatment?

### 1. CONSENT IS REQUIRED FOR ALL TREATMENT

As per the definition of the HCCA, tube feeding is considered treatment and requires consent. The following sections of the scenario illustrate how consent was obtained prior to implementing the tube feeding treatment for this client.

### 2. CLIENTS MUST HAVE THE CAPACIY TO GIVE CONSENT

If capacity has not already been established, the RD would need to determine whether the client has the ability to provide informed consent, meaning that he:

A) understands the information that is relevant to making a decision about the treatment; and

B) appreciates the reasonably foreseeable consequences of a decision or lack of decision.[1]

Although, the presence of a mental illness may bring into question a client's ability to understand and appreciate the treatment being proposed, a psychiatric diagnosis such as dementia does not automatically mean that they are not capable to make decisions about nutrition care.

It is also important to recognize that a person may be incapable of providing consent for some treatments and capable with respect to others; and/or a person may be incapable of providing consent to treatment some days (or periods within a day) and not others.[1]

## Need to Know

The fundamental laws and standards about consent are specified in the Health Care Consent Act (HCCA) and the College's Standards for Consent. These laws and standards are all based on respect for a client's rights to make informed decisions about their treatment. In the HCCA, treatment is defined as, "Anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan."[1] The College interprets this definition to include conducting nutrition assessments. Below are the nine key client-centred principles for obtaining informed consent in this scenario:

1. Consent is required for all treatment.
2. Clients must have the capacity to give consent.
3. If a client is not capable of giving informed consent, a substitute decision-maker must be identified.
4. The health care provider who is giving a treatment is responsible for ensuring that there is consent before the treatment is administered.
5. Consent must be informed.
6. Consent can be given for a multi-faceted treatment plan and course of treatment.
7. Depending on the situation, consent can be implied or given verbally or in writing.
8. Clients have the right to refuse treatment and/or withdraw consent at any time.
9. Express consent, the withdrawal of consent for treatment or the refusal of treatment must be documented.

In this scenario, the client has quite severe dementia and has been found not to be capable of providing informed consent to treatment. He is consistently unable to understand the information that is relevant to making a decision about his health care and to appreciate the reasonably-foreseeable consequences of making a decision or a lack of decision.

### 3. IF A CLIENT IS NOT CAPABLE OF PROVIDING CONSENT TO TREATMENT, A SUBSTITUTE DECISION-MAKER MUST BE IDENTIFIED

There is a note in the client's chart which indicates that the client's son is the substitute decision-maker. In cases where the substitute decision-maker is not yet assigned, section 20(1) of the HCCA provides the hierarchy of who is eligible for this role.[1]

Even if a client is deemed incapable of providing consent to treatment, RDs should strive to involve the client as best as possible in any consent to treatment decisions. The College has developed guidelines for dealing with incapable clients (see the *Jurisprudence Handbook for Dietitians in Ontario,* p. 82).[2]

### 4. THE HEALTH CARE PROVIDER WHO IS GIVING A TREATMENT IS RESPONSIBLE FOR ENSURING THAT THERE IS CONSENT BEFORE THE TREATMENT IS ADMINISTERED

The HCCA specifies that on behalf of all the health practitioners involved in the treatment, one health care practitioner may propose the plan of treatment.[1] The RD should be able to assume that the physician who ordered the G-tube has obtained informed consent for treatment. In this scenario, she was able to verify the consent by looking at the signed consent form in the client's health record.

### 5. CONSENT MUST BE INFORMED

The requirement for informed consent rests on the principle that clients (or their substitute decision-makers) have the right to consent or refuse treatment based on what is important to them. This self-determination may be expressed directly by the client or through their substitute decision-maker. In this case, to obtain consent for treatment, the physician would have addressed the following points with the substitute decision-maker:

- the nature of the treatment or assessment;
- who will be providing the intervention;
- reasons for the intervention;
- material effects, risks and side-effects of the intervention;
- alternatives to the intervention;
- consequences of declining the intervention; and
- specific questions or concerns expressed by the substitute decision-maker.[1]

The RD is well positioned to answer specific nutrition-related questions surrounding the tube feeding regimen (e.g., formula properties, rate of administration, side effects, etc.). Her role would be to engage the substitute decision-maker in the decision-making process to ensure he clearly understands the treatment being proposed and to address further questions or concerns.

### 6. CONSENT CAN BE GIVEN FOR A MULTI-FACETED TREATMENT PLAN AND COURSE OF TREATMENT

The HCCA defines "plan of treatment" as a plan that:

> "(a) is developed by one or more health practitioners;
>
> (b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition; and
>
> (c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition."[1]

In addition, section 12 of the HCCA specifies:

> "Unless it is not reasonable to do so in the circumstances, a health practitioner is entitled to presume that consent to a treatment includes,
>
> (a) consent to variations or adjustments in the treatment, if the nature, expected benefits, material risks and material side effects of the changed treatment are not significantly different from the nature, expected benefits, material risks and if the nature, expected benefits, material risks and material

risks and material side effects of the changed treatment are not significantly different from the nature, expected benefits, material risks and material side effects of the original treatment; and

(b) consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks or material side effects of the treatment as a result of the change in the setting in which it is administered."[1]

In this scenario, the physician obtained consent from the substitute decision-maker for the tube feeding treatment. As per section 12 of the HCCA, the RD can presume that this consent includes adjustments to the client's tube feeding regimen (e.g., formula/rate changes) that are not significantly different from the original treatment. Based on their professional judgement, RDs can decide whether the expected benefits, risks or side effects to the adjustments they make warrant further consent from the substitute decision-maker.

### 7. DEPENDING ON THE SITUATION, CONSENT CAN BE IMPLIED, GIVEN VERBALLY OR IN WRITING

The College requires RDs to comply with the HCCA and ensure that they have obtained informed consent for nutritional assessments and treatments.

In this scenario, the physician obtained the initial consent for tube feeding in writing. Consent for a nutrition assessment can often be implied, and in this case, the RD relied on implied consent to conduct her nutrition assessment. She walked into the client's room, introduced herself to the client and his substitute decision-maker and conducted a comprehensive nutrition assessment. The substitute decision-maker openly answered the questions about the client's health and nutrition history. He then asked the RD some detailed questions about the tube feeding regimen and the risks involved for his father. Given the nature of these probing questions, the RD felt that she had to confirm the initial consent obtained from the physician before proceeding with the tube feeding regimen. She answered the questions, made sure that the substitute decision-maker had a clear understanding of the process, the benefits and risks associated with the tube feeding treatment and verbally confirmed the consent to treatment.[1]

### 8. CLIENTS (OR THEIR SUBSTITUTE DECISION-MAKERS) HAVE THE RIGHT TO REFUSE TREATMENT AND/OR WITHDRAW CONSENT AT ANY TIME

In the scenario, the tube feeding regimen was initiated and the client was tolerating well. Two weeks later the client's daughter visited from overseas and was shocked to find her father on a G-tube. She expressed her concerns to her brother (the substitute decision-maker) and relayed a conversation which had taken place about three years previously, where her father commented that he would never wish to be tube fed.

Section 21 of the HCCA specifies that the person who gives or refuses consent to a treatment on an incapable person's behalf must do so in accordance with the wishes that the incapable person expressed while capable and take into consideration the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable."[1]

The substitute decision-maker asked his sister for more details about the context of their father's comment. Since the comments were made approximately three years before, she could not remember the particulars.

After much deliberation, further discussion with family members, and consultation with the health care team about other feeding options, the substitute decision-maker decided to continue with the tube feeding treatment. Since other feeding options were limited and his father was tolerating treatment well, he did not feel comfortable discontinuing the tube feeding based on a comment made by his father in the past.

### 9. EXPRESS CONSENT (VERBAL OR WRITTEN CONSENT), THE WITHDRAWAL OF CONSENT OR THE REFUSAL OF TREATMENT MUST BE DOCUMENTED

There are three key considerations for documenting consent:

**i.** the legal requirements of the HCCA

**ii.** professional judgment

**iii.** organizational policies

RDs must document express consent for nutrition assessment/treatment and exercise their professional

judgment to determine when implied consent should also be documented.

RDs must be able to assess when they can rely on implied consent or on express consent when a more formal oral or written consent is necessary. This decision will usually depend on the context in which the nutrition intervention is provided and the degree of risk to the client for following or refusing treatment. When documenting consent, RDs should consider organizational policies.

In this scenario, informed consent to treatment was documented by the physician through a signed consent form. The RD documented all follow-up discussions with the substitute decision-maker and, also, that she had obtained additional verbal consent prior to initiating the tube feeding regimen.

### ENGAGING CLIENTS

As illustrated in this scenario, obtaining informed consent is not only about filing a checklist to satisfy the law. At the heart of client-centred dietetic services, informed consent involves listening and communicating effectively to engage clients or their substitute decision-makers in the decision-making process.

By law, RDs have the responsibility to effectively communicate information and answer all questions to help clients exercise their right and responsibility to make informed decisions and consent to treatment. RDs with good communication skills will engage clients in the decision-making process, build trust and develop a respectful relationship. This is essential for transmitting the information clients or substitute decision-makers need to make informed decisions about treatment options.[3] In the end, it is the responsibility of the client or their substitute decision-maker to make a decision and consent to treatment.

### INFORMED CONSENT CAN BE COMPLEX

RDs may face some complex issues affecting how they obtain informed consent in their practice. There may be disagreement between clients and their substitute decision-makers, or the latter with other members in the family. In this scenario, because the sister thought that her father would not agree to the treatment, she objected to it and consent had to be revisited.

There may be issues surrounding end-of-of life decisions or living wills. In our diverse society, there are complex cultural sensitivities around faith, ethnicity, literacy, personal values, beliefs and language barriers, which may also have an impact on a client's ability to give informed consent. The RD is responsible in all cases for ensuring that treatment is not administered without informed consent.

A good knowledge of the Health Care Consent Act will help RDs manage the complexities surrounding consent. We encourage RDs to read the Act. It is easy to read and the requirements for consent and substitute decision-making are set out clearly. Based on a respect for client-centred decision-making and care, it articulates the fundamental principles to engage clients in exploring treatment options.

1 Health Care Consent Act. (1996). Available from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96h02_e.htm

2 Steinecke and CDO. (2012). Chapter 7: Consent to Treatment, Jurisprudence Handbook for Dietitians in Ontario, http://www.collegeofdietitians.org/Resources/Publications-CDO/Jurisprudence-Handbook-for-Dietitians-in-Ontario-(.aspx

3. Ibid. Chapter 2, p. 11.

## College Resources for Consent

Go to the College website at www.collegeofdietitians.org and enter "consent" in the search box.

- Professional Practice Standard: Standards of Consent to Treatment and for the Collection, Use and Disclosure of Personal Health Information
- The Circle of Care and Consent to Treatment (2005)
- Changes in the Plan of Treatment and Consent (2007)
- Documenting Consent (2009)
- Managing Conflicts Between RDs & Substitute Decision-Makers (2009)
- Consent to Treatment Based on Capacity, Not Age (2011)
- Complex Issues & Consent to Treatment (2013)
- Cultural Competence & Informed Consent (2013)

**Click here to test your knowledge about the informed consent.**