

Chapter 9

Consent to Treatment

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Defining Consent to Treatment

The term “consent to treatment” refers to the consent or agreement of a client to undergo an assessment process or treatment intervention, after gaining an understanding of the relevant facts and risks involved. The notion of consent to treatment stems from the legal and ethical principles that an individual has the right to decide what will be done to them. It is the responsibility of health care professionals to provide all of the necessary information to allow clients to make informed decisions about their care.

In this chapter, treatment also refers to professional services and the two terms may be used interchangeably but the obligations remain the same for both.

The obligations of Registered Dietitians and Registered Nutritionists related to consent to treatment are reflected in Section 2.2 of the College of Dietitians of Alberta *Code of Ethics* which states the following:

“2.2 Informed Consent

(2) The dietitian ensures that informed consent has been obtained for the provision of professional services in accordance with applicable laws and:

- a) Provides sufficient information to enable clients to make informed decisions about recommended services including information about expected benefits, risks, options, and alternatives;
- b) Communicates information using appropriate language, terminology and comprehension level to ensure understanding;
- c) Takes all reasonable steps to ensure that consent is not given under conditions of coercion or undue pressure;
- d) Provides new information when it could be significant or relevant to the original or ongoing informed consent in a timely manner;
- e) Respects the right of the client to refuse treatment or withdraw consent for care at anytime.”⁶³

KEY PRACTICE POINT

Ensure that the appropriate informed consent has been obtained from each client prior to provision of professional services.

The obligations of Registered Dietitians and Registered Nutritionists related to consent are also reflected in the *Standards of Practice*:

“Standard 8. Consent

Standard

Registered Dietitians obtain appropriate **client consent** in the provision of **professional services**.

Indicators

To demonstrate this standard, Registered Dietitians will:

- a) Provide clients with complete and objective information regarding the options for treatment and/or professional services and their respective risks and benefits as appropriate.
- b) Obtain client consent prior to the provision of services and document as required.
- c) Take all reasonable steps to ensure that consent is given freely, without evidence of coercion.
- d) Inform clients in a timely manner of proposed changes to the agreed-upon intervention plan and/or provide new information relevant to consent.

⁶³ College of Dietitians of Alberta. *Code of Ethics*; 2007.

- e) Respect clients' rights to: make choices, consult, and request additional information; refuse proposed interventions; and withdraw previously provided consent at any time.
- f) Obtain approval from the appropriate research ethics board and consent from clients participating in research studies.”

Elements of Consent to Treatment or Professional Services

In *A Physical Therapist's Guide to Consent*, author Mark Raven-Jackson, LLB of Field Law identifies four key elements that are required in order for consent to treatment to be considered valid. These are as follows (1):

1. *Consent to treatment must be given voluntarily.*

Consent to treatment must be given freely and not be obtained through undue influence or coercion. It is important to remember that when ill, many clients are anxious, receive a multitude of advice from well-meaning family and friends, and sometimes are intimidated by the inherent power of health care professionals (1). “Health care practitioners should always ensure that consent is given in an environment free of fear and compulsion from others.”⁶⁴

KEY PRACTICE POINT

Consent to treatment must be given freely and not be obtained through undue influence, coercion or by fraudulent misrepresentation of information.

In addition, consent to treatment must not be obtained by fraudulent misrepresentation of information. A practitioner may express an opinion as to a recommended course of action but must ensure that the client is given accurate and impartial information related to the nature of the treatment as well as treatment alternatives (1).

2. *The client must have the capacity to give consent to treatment.*

In order for consent to treatment to be valid, the person giving it must have the legal and mental capacity to give the consent. In *The Canadian Law of Consent to Treatment*, Rozovsky defines capacity as “the intellectual ability to reach a reasoned choice about treatment”⁶⁵. This suggests that a client understands the information given to them, is able to use the information in making a decision concerning their treatment and understands the consequences of their decision or a lack of decision.

² Raven-Jackson, Mark, LLB. *A Physical Therapists Guide to Consent*, 2000.

⁶⁵ Rosovsky, Lorne E., *The Canadian Law of Consent to Treatment*, Toronto: Butterworths, 1997, p. 6.

If a client has the capacity to give consent to treatment, no one else's consent is required. There are however, two groups in which concerns related to capacity often occur – these are minors and adults with disabilities.

Minors: In Alberta, children under the age of 18 years of age are capable of giving or refusing consent to treatment providing that they are able to appreciate the nature and purpose of the treatment and the consequences of their decision. If a child has the capacity to give consent to treatment, the consent of the child is required and considered sufficient in law. This is commonly referred to as the “Mature Minor” doctrine. If a professional decides that a minor is sufficiently mature, steps should be taken to document the basis for this finding. In such circumstances, consent to treatment from parents is not required; parents also may not override the decision of the child (1).

In the event that a child does not have the capacity to make a decision regarding their treatment, the child's parents or legal guardian have the legal authority to do so. However, in the event that the decision of the parents or legal guardian is

KEY PRACTICE POINT

Clients must have the capacity or intellectual ability to understand the information given to them and to use the information in making their decision to give consent to treatment.

not considered to be in the best interest of the child, the decision may be overridden. For example, if a parent or legal guardian refuses to give consent to a treatment that is considered to be in the best interest of a child, an application may be made for a Court Order authorizing the treatment pursuant to the *parens patriae* principle. Alternatively, Child Welfare Authorities may apprehend a “child in need of protective services” (which includes a child in need of necessary medical treatment) under the *Child, Youth and Family*

Enhancement Act. Refusal of parents and legal guardians to consent to necessary medical treatment may also result in criminal liability as outlined in the *Canadian Criminal Code* which requires that the necessities of life (including necessary medical care) be provided by the parents or legal guardians of a child under 16 years of age (1).

Adults with a Disability: In the event that a client lacks the capacity (whether temporary or permanent) to make a decision regarding their care, a substitute decision maker with lawful authority should be identified and give the proper informed consent to treatment prior to treatment being provided. An individual appointed as an Agent through a Personal Directive may, so long as the Personal Directive so provides, give consent to treatment on behalf of a client who does not have the capacity to make decisions regarding their care. If a Personal Directive is not in place, a Guardian may be appointed under a Guardianship Order by the court. Family members often act on behalf of clients who lack capacity to make decisions regarding their care; however, common law gives them no authority to do so (1). From a legal perspective, in the absence of an Agent or Guardian, the direction and input of family members only serves to inform health care professionals as to what is in the client's best interest. It should also be noted that the capacity of a client to make decisions regarding their care may be influenced by fatigue, pain, medications, etc. Consequently,

Canadian courts acknowledge that capacity may be transient. Therefore, capacity to make decisions regarding treatment may change and may need to be reassessed (2).

3. *The consent must refer to the treatment (or professional services) and the person who will administer it.*

In order to make an informed decision to consent to treatment, the client must be given a specific description of the treatment that will be provided; this information will serve to enable the client to gain a clear and accurate understanding of the nature of the treatment that will be provided. If the proposed treatment involves a series of steps or a course of treatment, the main elements of the treatment should be identified for the client (1).

Clients should also be informed of who will be administering the treatment, the qualifications of that individual and if any assistants will be present. Clients should also be informed and have the opportunity to give consent for students to be present during any treatment (1, 2). A survey conducted by Lynöe, Sandlund, Westberg, and Duchek found that 80% of clients were upset if they were treated by medical students without being informed. However, 88% of these same clients were in principle willing to participate in student training (3).

4. *The client must be informed.*

As previously indicated, consent to treatment is not considered valid unless a client is properly informed of the nature of the treatment, the consequences of providing or refusing consent, and the person who will be administering the treatment. In doing so, clients must, at a minimum, be informed of the following (1, 3, 4):

KEY PRACTICE POINT

Prior to giving consent to treatment, a client must be *fully* informed.

- The reason for and expected benefits of the treatment
- The effects, risks or side effects of the treatment
- All possible, reasonable alternatives to the treatment
- Consequences of refusing the treatment

Clients should also be given the opportunity to have their specific questions or concerns regarding the treatment addressed (1, 3, 4). It is important to remember that consent to treatment is more than a signed document – it is a communication and education process. The document only serves to create a paper trail of the process that occurred.

Types of Consent to Treatment or Professional Services

Consent to treatment may be implied or expressed by the client. Each of these types of consent to treatment are explained further below.

Implied Consent

In many situations, consent to treatment is simply implied through the words and / or conduct of a client. For example, Registered Dietitians and Registered Nutritionists frequently engage in a face-to-face consultation with clients. During such consultations, it is normal practice that the client is asked questions relevant to their nutrition status or is provided with education / counseling related to their nutrition care plan. By participating in such a dialogue and agreeing for the consultation to continue, the client has implied consent to treatment.

Expressed Consent

In circumstances where more specific dietetic interventions are required, a more formal approach to obtaining consent should be taken. Such interventions could include weighing a client, touching a client (i.e. measuring skinfold thickness, measuring waist circumference), ordering or administering a specific treatment regime (i.e. restricted diet, enteral / parenteral nutrition, behaviour modification therapy, etc.).

Expressed consent to treatment involves obtaining the consent or agreement of a client to undergo an assessment process or treatment intervention after the client has gained an understanding of the relevant facts and risks involved. Expressed consent to treatment may be given in a verbal or in written form. While legislation in Alberta does not require that consent to treatment be in written form, written consent, as noted above, is advantageous in that it creates further evidence of the process that took place. In situations where a written consent to treatment is not obtained, practitioners should document in the client chart that informed consent was given verbally.

A written “Consent to Treatment” form should include the following (1, 3):

- The printed name and signature of the client
- The date
- A clear and specific description of the proposed treatment that is understandable by the client
- The name of the person who will be providing the treatment or procedure
- Evidence that the client understands the following:
 - Why they should have the treatment or procedure
 - Alternatives to having the treatment or procedure

- The effects, risk and side effects of the treatment
 - What might happen if the client does not have the treatment
- The printed name and signature of a witness

It should be noted that in the event of an emergency situation, consent to treatment is not required if the delay in obtaining the consent would prolong suffering or place the client at risk of sustaining serious harm. Another example of a circumstance where consent to treatment is not required is when an enactment such as the *Public Health Act* or *Mental Health Act* dispenses with the need for consent to treatment.

Right to Refuse and Withdrawal of Consent to Treatment

KEY PRACTICE POINT

A client with the capacity to consent to treatment also has the right to refuse or withdraw consent to any treatment; if this occurs, the client should be made aware of the benefits and risks of the treatment to ensure that the refusal or withdrawal is informed.

A client with the capacity to consent to treatment also has the right to refuse or withdraw consent to any treatment, regardless of the consequences of their decision. "...the right to refuse unwanted medical treatment is so fundamental, it is protected not only by common law, but also by the Constitution, falling within the right to liberty and security of a person under Section 7 of the *Canadian Charter of Rights and Freedoms*."⁶⁶ This right is also affirmed in the *College of Dietitians of Alberta Code of Ethics*.

In the event that a client refuses or withdraws consent to treatment, the Registered Dietitian or Registered Nutritionist should ensure that the implications of refusal or withdrawal of consent to treatment is understood (5). When consent to treatment is withdrawn, Registered Dietitians should discontinue the intervention as soon as possible and advise the client on any necessary steps to stop the treatment safely (5). The decision to refuse or withdraw consent to treatment must be documented. Many health care facilities have policies and forms that must be signed by clients which indicate that they have made a choice to refuse or withdraw consent to treatment contrary to professional advice and that they are aware of and understand the risks of doing so (1).

KEY PRACTICE POINT

In the event that a client experiences harm while receiving care, full and complete disclosure must occur.

Disclosure of Harm to Clients

Health care professionals have an ethical responsibility to act in the best interests of their clients and to ensure that clients have all of the necessary information with which to make informed decisions about their care. However, in some situations, a

⁶⁶ Raven-Jackson, Mark, LL.B. *A Physical Therapists Guide to Consent*; 2000.

treatment or service provided may result in harm or potential harm to the client. In the event that a client experiences harm while receiving care, full and complete disclosure must occur (6). Harm is defined as “an unexpected or normally avoidable outcome that negatively affects the patient’s health and / or quality of life, which occurs or occurred in the course of health care treatment and is not due directly to the patient’s illness”.⁶⁷

The obligations of Registered Dietitians and Registered Nutritionists related to disclosure of harm are reflected in Section 1.4 of the College of Dietitians of Alberta *Code of Ethics* which states the following:

“(4) The dietitian discloses adverse events and takes all necessary actions according to established guidelines to minimize harm arising from an adverse event and to prevent recurrence.”⁶⁸

Prior to disclosing a harmful situation, Registered Dietitians and Registered Nutritionists are advised to refer to the policies and procedures of their employer. Care must be taken to ensure that the disclosure is handled in the appropriate manner, considering the following:

- What information will be disclosed?
- Who should disclose the information?
- To whom should the disclosure be made?

During a disclosure of harm meeting, it is important to use good communication techniques to ensure that the client and / or their family fully understand the nature of the discussion.

“The initial disclosure conversation should include:

1. An appropriate apology
2. Known and agreed upon facts
3. Patient’s questions / concerns
4. Consequences of harm and any side effects to look for
5. Discussion of ongoing care
6. What happens next (investigation of adverse event and feedback)
7. Arrangement for future meetings
8. Contact details in case of further concerns or questions”⁶⁹

⁶⁷ College of Physicians and Surgeons of Ontario. Disclosure of Harm Policy. 2003. Available from: <http://www.cpso.on.ca/Policies-Publications/Policy/Disclosure-of-Harm>

⁶⁸ College of Dietitians of Alberta. *Code of Ethics*; 2007.

When any disclosure of harm meeting takes place with a client and / or their family, it is important to document the details of the communication that occurred (6).

The Health Quality Council of Alberta has excellent resources to guide health care professionals in the disclosure of harm to clients. These resources may be accessed at the following web site:

https://www.hqca.ca/wp-content/uploads/2018/05/DCL_Framework.pdf (6)

⁶⁹ Health Quality Council of Alberta. *Disclosure of Harm to Patients and Families*. Provincial Framework. July 2006. Available from: <http://www.hqca.ca/index.php?id=58>

Chapter Summary

The term “consent to treatment” refers to the consent or agreement of a client to undergo an assessment process or treatment intervention, after gaining an understanding of the relevant facts and risks involved. Consent to treatment must be given freely and not be obtained through undue influence, coercion or by fraudulent misrepresentation of information. Clients must have the capacity or intellectual ability to understand the information given to them and to use the information in making their decision to give consent to treatment. Prior to giving consent to treatment, a client must be informed, at a minimum, of the following: the nature of the treatment that will be provided; who will be administering the treatment; the reason for and expected benefits of the treatment; the effects, risks or side effects of the treatment; all possible, reasonable alternatives to the treatment; and the consequences of refusing the treatment. Consent to treatment may be implied through the words and / or conduct of a client or expressed verbally or in written form. In the event of an emergency situation, consent to treatment is not required if the delay in obtaining the consent would prolong suffering or place the client at risk of sustaining serious harm. A client with the capacity to consent to treatment also has the right to refuse or withdraw consent to any treatment; if this occurs, the client should be made aware of the benefits and risks of the treatment to ensure that the refusal or withdrawal is informed. In the event that a client experiences harm while receiving care, full and complete disclosure must occur.

Case Scenario 9.1

JJ is an 80-year-old male who was admitted to hospital after suffering a cerebral vascular accident. Upon admission to the hospital, he signed a general consent to treatment form. The dietitian received a referral to see JJ regarding concerns that he was having difficulty chewing and required very long periods of time to consume meals. He had lost weight and was dehydrated. The dietitian completed a chart review on JJ noting his medical history, social history, height, weight, and laboratory data. She then visited JJ at which time she conducted a diet history, completed a physical assessment of JJ, including measurement of skinfold thickness. The dietitian determined JJ's nutritional requirements and in collaboration with him, developed a nutrition care plan to include softer, easy to eat foods. JJ's situation improved for a few days, but then he suffered another cerebral vascular accident after which he had severe difficulty with both chewing and swallowing. The dietitian requested a videofluoroscopic swallowing study. The results of the study indicated that JJ was unable to swallow any food consistency in a safe manner. The dietitian recommended enteral feeding until such time that it was determined that JJ was able to swallow without aspirating.

Case Scenario 9.1 Questions

1. Did the dietitian require consent to treatment from JJ when she completed the chart review? The diet history? The physical assessment? Measurement of his skinfold thickness? If so, what type of consent to treatment would be most appropriate?
2. Would JJ be required to provide consent to undergo the videofluoroscopic swallowing study? If so, what specific information would he require prior to making his decision?
3. Would any consent to treatment that JJ provided at the time that his initial nutrition care plan was developed and implemented still apply if enteral feeding is initiated? Explain your answer.

Chapter Quiz

1. All of the following statements are true *except* for the following:
 - a) “Consent to treatment” refers to the consent or agreement of a client to undergo an assessment process or treatment intervention after gaining an understanding of the relevant facts and risk involved.
 - b) Consent to treatment must be given by an individual who is 18 years of age or more in order to be valid.
 - c) Consent to treatment may be implied through the words and / or conduct of a client.
 - d) A client with the capacity to provide consent to treatment also has the right to refuse or withdraw consent to any treatment.

2. In order for a consent to treatment to be valid:
 - a) the client must be informed of the nature of the treatment that will be provided; who will be administering the treatment; the reason for and expected benefits of the treatment; the effects, risks or side effects of the treatment; all possible, reasonable alternatives to the treatment; and the consequences of refusing the treatment.
 - b) the client must have the intellectual ability to reach a reasoned choice about the treatment.
 - c) both the client and their family must be in agreement to give the consent to treatment.
 - d) All of the above
 - e) Answers a and b only

3. Which of the following is an example of “expressed consent”?
 - a) A client who will be undergoing psychonutrition therapy for the treatment of an eating disorder signs a form indicating their consent to treatment.
 - b) The parent of an infant who requires enteral feeding signs a form indicating their consent to treatment for their child.
 - c) A dietitian weighs a client after obtaining their verbal approval to do so.
 - d) All of the above
 - e) Answers a and b only

4. A written consent to treatment:
 - a) provides the best evidence that the client has given consent for a specific treatment.
 - b) should be signed by the client and a witness.
 - c) is required by law in Alberta.
 - d) All of the above
 - e) Answers a and b only

References

1. Raven-Jackson, Mark, LLB. *A Physical Therapists Guide to Consent*; 2000.
2. Kaier, H. A. Mental disability law. In J. Downie and T. Caulfield (Eds.). *Canadian Health Law and Policy*. Toronto: Butterworths; 1999.
3. Lynöe, N., Sandlund, M., Westberg, K., & Duchek, M. Informed consent in clinical training – Patient experiences and motives for participating. *Medical Education*, 32, 465 – 471; 1998.
4. Rosovsky, Lorne E. *The Canadian Law of Consent to Treatment*. Toronto: Butterworths; 1997.
5. College of Dietitians of Ontario. *Professional Practice Standard: Consent to Treatment and for the Collection, Use and Disclosure of Personal Health Information*. Revised 2019. Available at:
[https://www.collegeofdietitians.org/resources/standards/competencies/standards-of-consent-\(june-2017\).aspx](https://www.collegeofdietitians.org/resources/standards/competencies/standards-of-consent-(june-2017).aspx)
6. Health Quality Council of Alberta. *Disclosure of Harm to Patients and Families*. Provincial Framework. July 2006. Available from: https://www.hqca.ca/wp-content/uploads/2018/05/DCL_Framework.pdf