SEVEN

College of Dietitians of Ontario

# Consent to Treatment

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## NEED TO KNOW

1. Consent for treatment is always required, except in an emergency.

2. Consent is generally obtained from a client directly and can be verbal, in writing or, in some cases, by implication.

3. Where a client is incapable, the dietitian must obtain consent from a substitute decisionmaker.

4. There is no minimum age for consent; it is based on the capacity of the client.

# Informed Consent to Treatment

## SCENARIO 7-1
### Energy Supplementation

You work at a long-term care facility. A number of residents are identified as requiring additional energy in their meal plan. You are asked if it would be a good idea to put the energy supplement in mashed potatoes for 17 residents. The cook tells you that the residents won't even be able to taste the difference and will never know. You think the addition to their diet would make sense. What kind of consent would you need from the residents?

The requirement for informed consent rests on the principle that clients make their own treatment decisions. The role of the practitioner is to provide information and make recommendations that will enable clients to make informed decisions. Consent can be obtained in a number of ways, and can even be implied, and must be obtained (except in cases of emergency) for any therapeutic intervention. If a client is not capable of giving consent, a substitute decision-maker must be found.

In the scenario above, the first question is whether adding the energy supplement is treatment. Providing a balanced food diet might not be viewed as treatment; the facility would be performing the same role as a restaurant. However, adding a specific substance to food for a therapeutic purpose would be considered treatment. "Treatment" means any clinical intervention with a client and, for the purposes of informed consent, includes assessments.

Thus, some consent is needed, whether from the general consent obtained at the time of admission to the facility, or otherwise. Scenario 7-1, *Energy Supplementation*, illustrates the need to obtain consent in every case where one intervenes with a client. The fact that an intervention is positive is no reason to assume that consent is not needed. The principle that clients should make their own treatment decisions is based on a number of rationales.

- Individuals have control over their bodies. A health practitioner should not touch, examine or otherwise interfere with another person's body without true consent. Of course, meaningful consent requires that the client knows everything needed to make an informed choice.
- Health practitioners must provide high quality services to clients. In part, these include advising them of their options and partnering with them. The "best possible service" means just that for each particular client.[1]
- Health practitioners owe a fiduciary duty of good faith and loyalty to their clients. Often, health practitioners have a high status in our society. Health practitioners also have specialized knowledge and expertise. Clients often approach health practitioners such as dietitians at a time of need. For all of these reasons, clients are vulnerable in relation to the health practitioner, which places a corresponding duty on the health practitioner to act only in the client's best interests.

Scenario 7-2, *Refusal to Eat*, next page, illustrates the difficulties in accepting a client's wish when it's contrary to your own treatment orientated practice and personal values, particularly when relatives and colleagues take a different view. The issue here, however, is whether Veronica is able to give informed consent. Does she understand and appreciate the consequences of her decision? Is she depressed? If Veronica is fully capable, then her wishes need to be respected.

It is sometimes difficult to reconcile the principle of client autonomy, including the right to refuse treatment, with the duty to warn others about a client's intent to harm themselves discussed in Chapter 6. There are two main distinctions:

- First, where there is a concern that a client does not truly understand and appreciate what they are proposing, the duty to warn about client self-harm is more likely to apply. The decision is not an informed, autonomous choice.
- Second, the duty to warn results only in advising those who need to know about the contemplated self-harm. However, the people advised about the client's intent to

harm themselves usually still need informed consent to intervene; from the client, if capable, and from a substitute if the client is not capable.

## WHY INFORMED CONSENT IS NOT ALWAYS OBTAINED

Often there is a discrepancy between a health professional's belief that informed consent has been obtained and what actually happens in reality. Dietitians know that they are supposed to obtain informed consent, and generally believe that they do. However, some objective observers might question this assumption. There are several reasons for this discrepancy in perception:

- **Health care professionals assume a level of sophistication in their clients that often does not exist.** In Scenario 7-1, *Energy Supplementation* (p. 76), the dietitian might assume that the residents are familiar with dining room operations, and would know that additions are often made to food to address specific nutrition insufficiencies. However, dietitians must recognize that they live day in and day out with dietary matters, and that many other people never think twice about the nutrients contained in the foods they eat.
- **Health care professionals are rushed.** In today's environment of cutbacks and downsizing, there is tremendous pressure to provide nutrition care for an increasingly higher volume of clients, often combined with more complex assessment and treatment needs.
- **Poor communication skills.** Making assumptions or even making a statement is not communication. Communication involves feedback and understanding.
- **Ignorance of the requirements of informed consent.** While all dietitians know that they need informed consent, they often do not appreciate all aspects and responsibilities of this duty. Some wrongly assume that it only applies to invasive procedures such as surgery and the administration of drugs. Appropriately, these invasive activities are generally the focus of published standards and guidelines. However, all treatment decisions and many other matters, such as client assessments and the release of information, require informed consent.

### SCENARIO 7-2
Refusal to Eat

Veronica is sharp as a whip. But she is severely and painfully disabled. Recently the pain has been getting worse, and Veronica is having trouble taking the pain medication. In the last few days she has refused to eat. You have discussed the issue with Veronica a few times. While she has not been completely forthcoming, you are convinced that she is capable and is possibly choosing to end her life. Veronica's family is upset at her declining condition, and insist that she receive tube feeding. Veronica's physician agrees and provides the order. In discussing tube feeding with her, Veronica is adamant that she does not want it. What do you do?

## ELEMENTS OF INFORMED CONSENT

Often, consent can be quite informal. For example, when a dietitian asks a client questions about his or her medical history, a client generally demonstrates consent by answering them. However, whenever a dietitian touches a client, or orders or administers a treatment, a more formal approach should be taken. A client is entitled to know the following before any assessment or treatment is performed:

- **The nature of the treatment or assessment.** Don't assume that clients know what will happen next. It is generally prudent to explain exactly what you'll be doing and the manner or mechanism by which the nutrition intervention works.
- **Who will be providing the intervention.** Unless a client is unconscious, he or she will generally see who is administering a treatment. Some clients, dealing with professionals they have never met, may feel uncomfortable telling them to stop a treatment and asking for someone else to do it. Therefore, clients should be given some information about the professionals who will be treating them, e.g. whether the person is registered. For some procedures, it is also

prudent to communicate the gender of the person providing the treatment. If treatment will be provided at another time, it would be sensible to tell the client who will be administering it in advance.

- **Reasons for the intervention.** The client should understand the expected benefits of the procedure.
- **Material effects, risks and side-effects of the intervention.** One court has described it this way: "A risk is thus material when a reasonable person in what the [practitioner] knows or ought to know to be the patient's position would be likely to attach significance to the risk or cluster of risks in determining whether or not to undergo the proposed therapy." [2] In other words, a risk is material if a client would want to know about it.
- **Alternatives to the intervention.** Often, more than one treatment option may be available for a client. Some options have an influence on a client's choice because they may be more intrusive, painful or expensive than others. Although a dietitian may prefer a certain option, it is up to the client to decide on the best course of treatment. It is acceptable, however, for a dietitian to explain why certain options are not recommended and, in a general way, to explain the material effects, risks and side effects of alternative options. It is not acceptable to provide only the options that the treating dietitian is able to offer; all reasonable options should be presented, including those that other dietitians or even other health practitioners can provide.
- **Consequences of declining the intervention.** All clients should have an opportunity to consider the advantages and disadvantages of refusing treatment as well. This discussion should not create the impression, however, that the practitioner is attempting to coerce clients to agree to the intervention.
- **Specific questions or concerns of the individual client.** In addition to the general aspects of informed consent, dietitians should be sensitive to any particular concerns of individual clients. If the practitioner knows that an intervention could offend any religious, ethical or personal belief held by a client, then that issue should be discussed. In addition, any specific questions asked by the client need to be answered.

To give informed consent for treatment, a client must not only understand the information, but must also appreciate reasonably foreseeable consequences of the decision. For example, a client may understand that a modified texture diet would include pureed foods, but may not understand that favorite liquids such as tea or juice must be thickened to decrease the risk of aspiration.

Consent may be given for a course of treatment (e.g. the ongoing adjustment of a diet for clients with renal disorders) or a plan of treatment (e.g. a diabetes management program involving a health care team). Once given, the consent applies to the entire course or plan of treatment, unless there is a significant change in circumstances or consent is withdrawn.

Normally, it is the responsibility of the person proposing the course or plan of treatment to obtain consent. However, if the person proposing the treatment is not able to obtain the consent (e.g. because they do not know all of the material risks and benefits, etc.), someone else may have to do it. Even where a member of the health care team has obtained consent for the course or plan of treatment, it is prudent to check with the client before implementing one's own intervention to ensure that the consent was informed and has not been withdrawn.

For repetitive matters, it is acceptable to give a written description of the information that the client needs to know. This will often save considerable time. However, there should always be some individual discussion with clients after they have read the treatment description, to ensure they understand the information, appreciate the implications, and have all their questions answered. Some clients are functionally illiterate and hesitant to disclose this fact. So, simply asking, "Did you understand what you read?" is often not enough.

## Implied Consent to Treatment

Consent to treatment need not always be obtained in writing or even verbally from a client. In many circumstances, such as a routine assessment, a written consent is impractical. While formal, documented consent is not always required, dietitians need to be sensitive and confident that they have actually obtained consent.

An express written consent offers proof should a subsequent challenge arise. Yet as Scenario 7-3, *Implied Consent* illustrates, consent is often obtained informally. An express statement from the client was not necessary for the consent to be valid, and the risk involved in a client receiving a reduced fat diet was minimal. While not a "best practice", relying on the client's implied consent was probably sufficient in this scenario.

If a particularly risky intervention is recommended, or if a client appears unreliable, then a written consent can help a dietitian prove that a proper consent was obtained. The consent form should be simple and easy to understand. A sample consent form is set out in Figure 7.2. Dietitians need to carefully fill in the blanks, using language that is easy to understand. If desired, they can add an explicit acknowledgement of understanding for a particular risk or side-effect; for example, introducing fibre in large amounts too quickly may result in abdominal cramping and bloating.

Written consent forms are not a complete defence to an allegation of failing to obtain consent. Dietitians sometimes confuse a signed consent form with obtaining informed consent. A written consent form is simply a piece of paper, unless it is read, understood and appreciated. Obtaining informed consent is a process that involves the meeting of minds.

The client can still claim that the form was not clearly explained before his or her signature was obtained, or that he or she did not understand or appreciate what was signed. Therefore, the written consent form should not be obtained in a rushed or routine fashion. It should never be obtained with the client's initial registration with the office, facility or clinic, unless it is already known what intervention will occur. What, then, is the benefit of a written consent?

### SCENARIO 7-3
Implied Consent

You work in a public hospital and speak with a client about a reduced fat meal plan. You have a good discussion about the goals and methods of reducing fat consumption, and have found a means to achieve the meal plan agreeable to him. At the end of the meeting, you say, "I will initiate a low fat meal plan for you starting tomorrow. You should know that you won't be getting ice cream for desert." As you leave, you realize that the client never actually said yes. However, you are sure that he was with you on the point and was not objecting. Do you need to go back and get an express consent?

Should a problem occur, a clear and simple signed consent form, witnessed by the attending dietitian or another person, places a heavy onus on the client to explain why he or she signed the form without fully understanding it. If a written consent is not obtained for particularly risky procedures, practitioners should document in the client's chart that an informed consent was given verbally. A note in the chart is also prudent when the client appears to be unreliable. A useful tip is to document the reason why a client chose one treatment option over another. Such a note is valuable supportive evidence that the dietitian actually obtained informed consent.

## Withdrawal of Consent to Treatment

Consent can be withdrawn. If a client consents to a course of treatment but then changes their mind, the dietitian can no longer rely on an earlier consent. This new decision must be respected.

A written consent can also be verbally withdrawn. However, the dietitian may ask the client to confirm the withdrawal of consent in writing so that there is a record. Also, the risks and benefits of the decision to withdraw consent should be reviewed to ensure that the withdrawal of consent is informed.

## Consent for Incapable Clients

### SCENARIO 7-4
### Developmentally Challenged Client[4]

A family physician refers you, a home care dietitian, to teach a 29-year-old developmentally challenged female, who lives alone, nutrition management of her newly diagnosed insulin-dependent diabetes. The client is able to provide what seems like an accurate record of her daily food intake.

When you explain the relationship of food intake to insulin, the need for regular meals and snacks, and the need to follow a daily meal plan, the client becomes quite agitated. She repeats several times that she had no idea that "the diet would be forever" and that she wants to eat like a regular person. When you try to reassure her that you will work with her to set up a meal plan that she will be able to follow, she begins to cry. At this point, you suggest that you will come back again to talk again about her diet.

The next day, using food models, you try to show her how the meal plan will work. Again, the client is distressed and states that she doesn't believe that the meal plan is important and she doesn't think anything will happen if she skips meals. After the visit, you contact the referring physician, who says that he feels the client is capable of understanding her diabetes and the treatment implications. He reiterates that the diet is an essential component of her treatment. You call the home care nurse, who says that the client is able to draw and inject her insulin independently. She does tell you, however, that the client lives close to her parents and that her mother is involved in some aspects of her care. What do you do?

Scenario 7-4, *Developmentally Challenged Client*, illustrates the complexity of determining whether a client is capable of giving informed consent for a particular treatment. Sometimes clients can be capable for some decisions and not others.

If you determine that a client is not capable, then you must obtain consent from the appropriate substitute decision-maker. The key issue in this scenario is whether the client understands and appreciates the consequences of her decision. Her statement at the second visit, that she doesn't believe that the meal plan is important and she doesn't think anything will happen if she skips meals, raises serious doubts about whether the client appreciates the consequences of her decision. The dietitian, while considering the views of the referring physician and the home care nurse, has to make his or her own assessment of whether the client is capable of making this particular decision.

Sometimes, there is confusion about the role of the Consent and Capacity Board in making findings of incapacity. It is rare for the Board to become involved in individual treatment decisions (where they do, it is usually after the fact, i.e., in an appeal of a finding that a person is not capable of making decisions). Unless the Board has made a general finding of incapacity about the client, it is the responsibility of the front line practitioner to determine the client's capacity for the individual treatment proposed. In this case, the dietitian would not determine the client's general capacity, but rather whether the client was capable of making a decision about the specific dietary changes being recommended.

The *Health Care Consent Ac*t (HCCA) provides a useful model for obtaining consent from a substitute decision-maker, which can be applied in all cases. While it provides detailed guidance for obtaining consent from a substitute decision-maker, where a client is incapable, it does not expressly cover all forms of intervention. Case law, however, does require that consent be obtained for all interventions (other than emergencies). Therefore, prudent practitioners should follow the procedures set out in the HCCA for all matters.

## DETERMINATION OF CAPACITY

Clients are assumed to be capable. An assessment of a client's capacity may be made only when there is reason to doubt it. However, a specific set of rules does not exist for determining the capacity of a client. When reservations about a client's capacity exist, a dietitian can perform an assessment to determine capacity based on the condition of the client and the nature of the proposed service. As noted above, the assessment is only of the client's capacity to make a particular treatment decision, not the client's general capacity.

For the purposes of a dietitian's interactions with a client, a general assessment of the capacity or incapacity is not required. The assessment should simply determine whether a client is capable of giving informed consent to a proposed treatment or service. A client may be capable of consenting to some treatments or services that are simple to understand, but not for those that require the analysis of complex considerations (for example, Scenario 7-4). In addition, a client may be capable during some periods but not others. For example, with some forms of dementia, a client may have "good days" and "bad days".

In each case, the dietitian must assess whether the client understands and appreciates the reasonably foreseeable consequences of a decision. The assessment of capacity must be based on observations about the client (apparent confusion) rather than on presumptions, generalizations or stereotypes (age, diagnosis, disability).

There is no minimum age for consent. As a general guideline, a dietitian may often find that:

- Children under 7 are incapable of consent for almost any treatment;
- Children between 7 and 12 can rarely consent to treatment; and
- Youth over 12 need to be carefully assessed as to their capacity on a case-by-case basis.

## SUBSTITUTE DECISION-MAKERS

When a client is incapable of giving consent, it must be obtained from a substitute decision-maker (unless there is an emergency). The substitute decision-maker must:

- be at least 16 years old (unless the substitute is the parent of the client);
- be capable;
- be able and willing to make the decision; and
- act in accordance with either the last capable wishes of the client, if any, or in the best interests of the client.

A dietitian has some obligation to intervene if it is clear that the substitute is not fulfilling his or her obligations. In some cases, explaining the obligations to the substitute is sufficient. In other cases, for example if the substitute is culpable of misconduct, the dietitian would be required to make a report to the Public Guardian and Trustee.

For certain decisions, an opinion from an independent evaluator may be required. For example, under the *Health Care Consent Act*, an evaluator's opinion may be required for the admission of an incapable person to a care facility. Dietitians may act as an evaluator for this purpose. [4]

## THE PRIORITY DECISION-MAKER

### SCENARIO 7-5
Non-Custodial Parent

Robert calls wanting to see you right away about his 8-year-old daughter Olivia. Olivia is with him for the day and has to be returned to her mother the next morning. Robert is concerned that Olivia is not being adequately fed by her mother, and wants you to assess Olivia. On questioning, you learn that Robert is not the custodial parent; he just has access rights. He says there is no provision in their separation agreement about his right to authorize medical care for Olivia. What do you do?

In this scenario, *Non-Custodial Parent*, consider the following points:

- Assessments require informed consent. While the *Health Care Consent Act* does not expressly require it, professional standards and case law do.
- While a health care professional is not supposed to rely on age to determine the capacity to consent, the reality is that few, if any, 8-year-olds would be able to appreciate the potential consequences of agreeing to this assessment.
- It is possible that at some point you could have a reasonable suspicion that Olivia was a child in need of protection. For example, if you saw Olivia in the waiting room, her appearance, along with Robert's information, could provide grounds for such a report. Indeed, you might even be in that position simply by obtaining sufficient information from Robert, although you would be cautious about his objectivity.
- To determine whether Robert can provide substitute consent, you need to know if he is a custodial or access-only parent, and inquire about the terms of any separation agreement or court order. Table 7-1, *Substitute Decision-Makers Ranked Highest to Lowest*, on the next page, lists the substitute decision-makers in priority from highest to the lowest. If a higher ranked substitute decision-maker would object, a lower ranked substitute usually cannot give consent.

As a practical matter, when dietitians are dealing with a family member of an incapable client, they merely have to establish:

1. Whether the family member knows of any formally appointed substitute; and, if not,
2. Whether the family member knows of another higher ranked substitute who would object to the family member making the decision.

If a formally appointed substitute (such as a power of attorney or another higher ranked family member) would object to a decision, then the dietitian cannot rely on the lower level substitute to make it. The dietitian must try to obtain consent from a higher level substitute if they are available and willing. In this example, you would have to obtain consent from Olivia's mother, the custodial parent, for her nutritional assessment.

### COLLEGE GUIDELINES FOR DEALING WITH INCAPABLE CLIENTS

Dietitians will want to keep the incapable client as involved as possible in their treatment and personal service decisions. The following guidelines have been developed by the College of Dietitians of Ontario:

1. The dietitian will inform the incapable client that they will need a substitute decision-maker to assist them in understanding the proposed intervention, and that the substitute decision-maker will be responsible for the decision regarding treatment.
2. The dietitian will inform the client of the substitute decision-maker's name.
3. The dietitian will involve the incapable client, to the extent feasible, in discussions with the substitute decisionmaker.
4. If the client disagrees with the substitute decision-maker, the dietitian will offer to assist the client to identify another substitute decision-maker of the same or more senior rank. If the client indicates that they are still uncomfortable with the substitute decision-maker, the dietitian will also inform the client that he/she may apply to the Consent and Capacity Board for the appointment of a representative of the client's choice.
5. If the client disagrees with the finding of incapacity, the dietitian will inform the client of the right to appeal the finding of incapacity to the Consent and Capacity Board for review. If the client requests clarification on this finding, the dietitian will give the client the name of the health professional who made the finding.

## Emergencies

In an emergency, consent is not needed when the delay in obtaining it would prolong suffering or put the client at risk of sustaining serious bodily harm. The definition of what

constitutes an emergency is set out in the *Health Care Consent Act*. In particular, an emergency includes circumstances where a client "is apparently experiencing severe suffering" or is at risk of "sustaining serious bodily harm". In addition, an emergency can exist when a client is capable, but communication or language difficulties create a barrier causing a serious delay in treatment, and there is severe suffering or a risk of serious bodily harm.

One of the rare situations where a dietitian will face an emergency is when force-feeding anorexic clients. As noted above in Scenario 7-2, *Refusal to Eat*, if a client is capable, he or she can refuse to eat. Force-feeding can only occur if the client is incapable and there is an emergency (i.e. consent or refusal cannot be obtained on a timely basis) or a substitute decision-maker consents to it. [5]

FIGURE 7-1
Substitute Decision-Makers Ranked Highest to Lowest

1. Guardian of the person appointed by the courts;
2. Attorney for personal care conferred by a written form when the client was capable;
3. Consent and Capacity Board appointed representative;
4. Spouse or partner;
5. Child or custodial parent;
6. Access parent;
7. Brother or sister;
8. Any other relative;
9. Public Guardian and Trustee.

Where a substitute from the first three on this list is able and willing to make the decision, then he or she must be used. At the family member level, any available substitute on the list can be relied upon, so long as no higher ranked substitute is available who is known to want to make the decision (see discussion below). The Public Guardian and Trustee, a government official, is relied upon as a last resort.

For more information about the *Office of the Public Guardian and Trustee for Ontario*, see: http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/

## Conclusion

Dietitians must understand the complexities of the legal requirements for consent to treatment. It is important to remember that consent is always required for treatment, except for an emergency. Written, verbal and implied consents are all valid, but in the latter case, dietitians should be sensitive to their clients' treatment needs and wishes. They should also remember that capacity to consent is not age related, but depends on a client's ability to understand the scope of the treatment and its consequences. In cases where clients are not capable of consent, a substitute decision-maker has to be found.[5]

1 Dietitians of Canada and College of Dietitians of Ontario. *Professional Standards for Dietitians in Canada*. Toronto: 1997, Standard 1, page 6.

2 Hoop c. Lepp, [1980] 2 R.C.S. 192.

3 Effective December 15, 2009, for the purposes of the *Health Care Consent Act,* Registered Dietitians have been permitted to act as an evaluator to find a person capable or incapable of providing consent with respect to admission to a care facility where consent is required by law. This change enabled dietitians to work as Case Managers within *Community Care Access Centres* (CCACs).

4 Adaptation of the example from College of Dietitians of Ontario, *Health Care Consent Act* (HCCA) Guidelines for Members (HCCA).

5 Lisa Braverman, "The Application of the *Health Care Consent Act* to the Force Feeding of Anorexic Patients", *Health Law Review* 1997: Vol. 5, No. 2, p.25-32.

FIGURE 7-2

# *Consent Form*

I hearby consent to the following treatment:

*Describe treatment as specifically as possible but in words that are understandable to lay people.*

I have been told about the following:

- ☐ What the treatment is
- ☐ Who will be providing the treatment
- ☐ The reasons why I should have the treatment
- ☐ The alternatives to having the treatment
- ☐ The important effects, risks and side-effects of the treatment and the alternatives to the treatment [consider adding "including the following: {list major risks}"];
- ☐ What might happen if I do not have the treatment?

I understand the explanation and have no further questions.
My consent is voluntary.

Date

WITNESS SIGNATURE

SIGNATURE OF CLIENT

PRINT NAME OF WITNESS

PRINT NAME OF CLIENT

## Quiz

Provide the best answer to each of the following questions. Some questions may have more than one appropriate answer. Explain the reason for your choice. See *Appendix 1* for answers.

1. **In Scenario 7-1, "Energy Supplementation", what should the dietitian do?**
   a. Nothing, the residents are not the dietitian's client.
   b. Nothing, the residents signed blanket consent forms at the time of admission to the facility.
   c. Nothing, energy supplementation is not a treatment.
   d. Ensure that informed consent is obtained.

2. **In Scenario 7-4, "Developmentally Challenged Client", is the client capable?**
   a. Probably not, since the client does not appear to understand the material considerations.
   b. Probably not, since the client does not appear to appreciate the reasonably foreseeable consequences of her decision.
   c. Probably not, as she is developmentally challenged.
   d. Probably yes, since she is capable for other treatment decisions having life altering consequences, such as the need to take insulin injections.

3. **In Scenario 7-4 "Developmentally Challenged Client", what should the dietitian do?**
   a. Do not accept the physician's and home care nurse's view of capacity at face value.
   b. Speak to the client about involving her mother in this treatment.
   c. Seek the involvement of the mother so long as there are no known higher ranked substitutes.
   d. All of the above.

4. **A signed written consent from a client:**
   a. Is the best protection you can have for a risky treatment decision.
   b. Is better than a verbal consent.
   c. Provides some evidence of informed consent.
   d. Needs to be witnessed to be effective.

5. **A client can withdraw consent:**
   a. At any time.
   b. Only in the same form in which the consent was originally given (e.g. in writing, verbally).
   c. If it is informed.
   d. Through a power of attorney for care.

# Resources

COLLEGE OF DIETITIANS OF ONTARIO

***Code of Ethics Interpretative Guide (I999).***

***Dietitians of Canada and College of Dietitians of Ontario.*** *Professional Standards for Dietitians in Canada.* Toronto: 1997.

***Guidelines: Health Care Consent Act (HCCA).***

***Articles at www.collegeofdietitians.org . Enter topic in the search box:***

- "The Circle of Care and Consent to Treatment", Winter 2005, 9-11.
- "Changes in the Plan of Treatment & Consent", Winter 2007, 4-5.
- "Documenting Consent", Summer 2009, 12-13.
- "Managing Conflicts Between RDs & Substitute Decision-Makers", Fall 2009, 6-8.

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**Hoffman, B.F.** The Law of Consent to Treatment in Ontario, 2nd ed. Toronto: Butterworths Canada Ltd., 1997.

**Rozovsky, L.E.** *The Canadian The Canadian Law of Consent to Treatment*, 2nd ed. toronto: Butterworths Canada Ltd., 1997.

LEGISLATION

**Office of the Public Guardian and Trustee for Ontario,** *Substitute Decisions Act*, S.O. 1992, C30.

**Health Care Consent Act, S.O.** 1996, chapter 2, Schedule A.