Health Care Consent in relation to Advance Care Planning

Information session for Healthcare Providers

Health Care Consent in relation to Advance Care Planning

Created by
The Ontario Health Care Consent and Advance Care Planning Community of Practice October 2013

Sponsored by the Alzheimer Knowledge Exchange

Presentation Goals

- To promote an understanding of Health Care Consent (HCC)
- To review terms and concepts
- To review Health Care Provider role in Health Care Consent and promoting "Advance Care Planning"
- To share resources

Why talk about Health Care Consent?

- It is your professional practice responsibility
- To promote client directed care
- To dispel misconceptions and promote knowledge
- It is the law

How we live and die has changed.

Case #1

Mrs. Anderson a widow who lives in a nursing home, falls and breaks her hip. During surgery, she has a heart attack, is resuscitated and remains on a ventilator.

Her condition remains unchanged despite maximum medical treatment. You need to get consent for a plan of treatment for CPR.

How confident are you in engaging in this discussion?

Case #2

Mr. Tang has been called to the emergency department as his wife was involved in a motor vehicle accident and is in critical condition. She has serious head and neck injuries, multiple organ trauma and is on life support. The physicians are looking for direction from Mr. Tang in regard to a plan of treatment. It is unlikely that she will recover and interventions under consideration include ventilation discussions, artificial feedings, and CPR.

Where will you start and what resources will you have to help guide your discussion?

Case #3

Mr. Singh is a 68 year old man with early stage Alzheimer disease. Mr. Singh is married with 4 adult children and he has had a recent problem with his prostate. A biopsy is suggested by the physician.

Who do you speak to about consent for this treatment?

Health Care Consent (HCC)

- HCC development was based on case law
- HCC is about the principles of respect and individual autonomy
- HCC is valid if it occurs within the rules that govern it

When must you obtain consent?

For anything that is done for:

- Therapeutic
- Preventative
- Diagnostic
- Cosmetic
- Or other health related purpose

This includes a course of treatment or a plan of treatment

Consent

Health Care Providers must get consent or refusal of consent to any treatment

- From the person if capable
- Or the Substitute Decision Maker(s) [SDM(s)] if the person is not capable

Except...

In an emergency, if the person is not capable and there is no SDM available, the Health Care Provider must follow the known wishes of the person or in the absence of known wishes they must act in the person's best interest.

Defined in the act as – Emergency means the person is experiencing severe suffering or is at risk of serious bodily harm.

Elements of Consent

- Must relate to the treatment
- Must be informed
- Must be given voluntarily
- Must not be obtained through misrepresentation or fraud

What information needs to be provided

- Nature of the treatment
- Expected Benefits
- Material Risks
- Material side effects
- Alternative course of action
- Likely consequences of not having the treatment

The Health Care Practitioner:

- Must provide information in a way that the person or SDM(s) can understand it
- Must apply the "Reasonable Person Standard"
- Must answer any additional requests for information

Consent must relate to a current illness

A person can give an informed consent to a treatment that will take place or be withheld in the future if the decision for that treatment is relevant considering the person's **present health condition.**

This is not "Advance Care Planning"; this is Consent

Can a person say 'no' to a treatment?

Basic answer - YES

Even if the decision doesn't appear to be in his/her best interest – YES

Every effort should be made to ensure the person understands and appreciates the consequences of a decision each and every time a treatment is proposed.

Capacity

- Capacity has **absolutely nothing** to do with the Health Care Provider's opinion as to the rightness or wrongness of a decision being made.
- Capacity only speaks to the quality of the understanding and appreciation that goes into making a decision.
- Capacity is not defined by age. The same concepts apply to children and adults about understanding and appreciating.

Capacity

A person is capable when:

- She/he is able to understand the information
- She/he can appreciate the consequences of the decision

Consent and Capacity

When a person is determined to be incapable, the person's Substitute Decision Maker(s) [SDM(s)] provide consent to care and treatment on the person's behalf.

Substitute Decision Maker(s) [SDM(s)]

A Substitute Decision Maker(s) [SDM(s)] is a person(s) who makes care and treatment decisions on another person's behalf if and when that person becomes incapable of making these decisions.

Who is the SDM for the incapable person?

The law provides a list of people who can act as the SDM(s) (Hierarchy of SDM's)

The list is arranged in order of legal priority (ranked)

Hierarchy (a ranked list) of Substitute Decision Makers

1. Guardian of Person
2. Attorney named in a POAPC
3. Representative appointed by Consent and Capacity Board
4. Spouse or Partner
5. Child or Parent or CAS (Person with Right of Custody)
6. Parent with right of access
7. Brother or Sister
8. Any other relative
9. Public Guardian or Trustee

Health Care Consent Act 1996 (HCCA)

Substitute Decision Maker (continued)

All persons on same level have equal ranking (i.e. all brothers & sisters rank equally, all children are equally ranked)

Persons in Ontario always have a SDM even if they have not appointed one or do not have any relatives as listed (Ontario Public Guardian and Trustee office)

SDM (s) Criteria

Must be:

- Capable with respect to the treatment
- At least 16 years of age
- Not prohibited through court order
- Available and willing

Role of the SDM(s):

Make decisions based on:

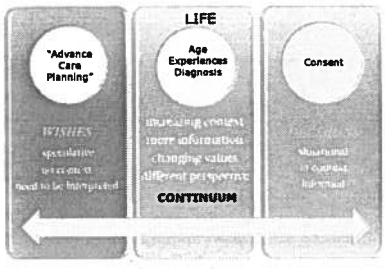
- the person's prior expressed wishes
- what the incapable person would want if he or she was capable
- the best interests of the person

If wishes are not known or cannot be honored, then decisions are based on the person's best interest

Role of the Health Care Provider (HCP)

- Inquire about goals, values, beliefs
- Clarify understanding of the diagnosis
- Provide information
- Discuss prognosis; treatment/care outcomes
- Provide information on the **proposed** treatment (nature, benefits, risks, side effects, alternative courses of action and consequences of not having the treatment
- Answer any questions

How does this relate to "Advance Care Planning"?



Adapted from: HCC-ACP presentation –HNHB LHIN November 2012

"Advance Care Planning"

- A **process** of reflection and communication
- The communication of **wishes** (verbal, written or otherwise)
- A way to let others know your future health and personal care **wishes**
- The consideration of who will speak for you when you are no longer capable of directing your care (SDM)

"Advance Care Planning"

- It is about communicating your wishes now, while you are **capable**, on how you wish to be cared for in the future if you become incapable of providing consent.
- It may also involve giving someone you trust the information and authority to act on those wishes for you. This person(s) is called a Substitute Decision Maker(s) [SDM(s)].

Why is "ACP" important?

Research has shown that:

- If wishes are expressed in advance, a person is more likely to have end-of-life wishes known and followed.
- Family members will have less stress and anxiety –because they know the person's wishes.
- The person is more satisfied with care (along with their family and SDM).
- The person will have a better quality of life and death.
- People hope that they will be able to communicate until the very end but most deaths do not occur this way.

National Speak Up Campaign- www.advancecareplanning.ca

Power of Attorney for Personal Care (POA

- A Power of Attorney is a legal document in which one person gives another person the authority to make personal care decisions on his or her behalf if he or she becomes incapable.
- In the document the person is referred to as ***an attorney for personal care*** (this person is the Substitute Decision Maker).

Expression of Wishes

- Oral wishes are as valid as written wishes
- Written wishes may be changed by later oral wishes
- Oral wishes expressed to a Health Care Provider should be recorded in the persons chart or plan of treatment

Written Wishes

- No specific format
- A person can appoint an SDM(s) only through completing the legal document **POAPC**
- Facilities or agencies cannot require an "Advance Directive" or other written wishes as a condition of admission or provision of care

Consent vs. Wishes

- Health Care Professionals must get informed **consent** (from the person if capable or the SDM(s) if not capable). Consent is related to specific care or treatment(s) offered in relation to a **current** health condition.

- **Wishes** are **not** consent
  a) Based on "if" scenarios (speculations) – "If I have a terminal condition.." "If I am in pain.." "If I have dementia…" "If that happens to me.."
  b) May relate to a known condition (ALS, Alzheimer's etc.)
  c) Based on beliefs, values and goals

Adapted from: Advocacy Centre for the Elderly November2012

Levels of Care Forms

- A common but misguided and misinformed practice.
- Does not relate to an individual's specific health condition.
- Is not a plan of treatment based on informed consent.

"Allow natural death"

"Allow natural death" is a term you may hear in connection with "Do Not Resuscitate."

Using "allow natural death" may imply that rather than engaging in attempts at resuscitation, efforts are directed at being present with the person and supporting the family at the time of death.

"Allow natural death" is a term used in conversation, not a specific treatment.

Health Care Provider Role

Health Care Providers are required to get informed consent (to deliver, withhold or withdraw treatment).

Discussions of "Advance Care Planning" are additional and related conversations that will help and support the ongoing process of values, beliefs and goals clarification, health care decision making and consent to treatment.

Health Care Provider Role in "ACP"

- Promote the process of reflecting on values, beliefs and goals.
- Discuss why/when someone might complete a POAPC.
- Provide information on hierarchy of future SDM(s) to determine if the hierarchy will meet the person's needs.
- Provide health and treatment information.

Health Care Provider Role in "ACP" - Speak Up!

National campaign to raise awareness of "Advance Care Planning"

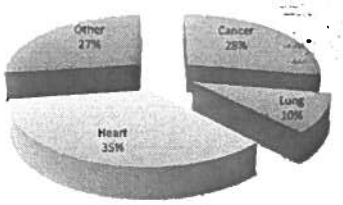
Website with resources to support "Advance Care Planning"

National "Advance Care Planning" Day - April 16th

Health Care Provider Role in avoiding conflict

- Understand the law, it's implications and where to get clarification
- Avoid becoming adversarial
- Identify differences and common ground
- Explore the person/SDM(s)/family fears
- Provide resources and information

Most Canadians die of a chronic illness



National Speak Up Campaign- www.advancecareplanning.ca

In Summary : "Advance Care Planning" is:

- A process of reflection and communication about values, beliefs and goals of care
- A process of planning for a time when a person cannot make care and treatment decisions (sharing wishes)
- A process that involves discussions with family, friends and Health Care Professionals
- A process in which a person may appoint a SDM(s)
- A process that results in the sharing of a person's wishes

In Summary :
What "Advance Care Planning" is not:

- One conversation only about treatment options with physician or other Health Care Provider(s)
- Consent to a treatment(s)
- Strictly a refusal of medical treatments
- A document /form /checklist to be completed
- A secret from the persons family or SDM(s)

Summary

- **Wishes** in an "Advance Care Plan" (or a conversation) guide the person's future SDM(s) to make health care decisions if they become incapable
- **Wishes** are interpreted by the **SDM(s)** when the person is deemed incapable
- **Health Care Providers** are required to get **consent** from the person (if capable) or their SDM(s) (if incapable) prior to initiating care or treatment of any kind in any situation

Case #1

Mrs. Anderson a widow who lives in a nursing home, falls and breaks her hip. During surgery, she has a heart attack, is resuscitated and remains on a ventilator. She remains unresponsive, and her condition remains unchanged despite maximum medical treatment. You need to get consent for a plan of treatment for CPR.

How confident are you in engaging in this discussion?

Case #2

Mr. Tang has been called to the emergency department as his wife was involved in a motor vehicle accident and is in critical condition. She has serious head and neck injuries, multiple organ trauma and is on life support. The physicians are looking for direction from Mr. Tang in regard to a plan of treatment. It is unlikely that she will recover and interventions under consideration include ventilation discussions, artificial feedings, and CPR.

Where will you start and what resources will you have to help guide your discussion?

Case #3

Mr. Singh is a 68 year old man with early stage Alzheimer disease. Mr. Singh is married with 4 adult children and he has had a recent problem with his prostate. A biopsy is suggested by the physician.

Who do you speak to about consent for this treatment?

Summary Activity

- Where will you start?
- What do you need to consider?
- Who will be making decisions?
- What information do you need to provide in order to obtain informed consent?
- What resources do you have to aid the discussion?

Take Home Messages

- Wishes/ "Advance Care Plans" are directions to SDM(s) NOT to Health Practitioners.
- Wishes are interpreted only by SDM(s).
- Health Care Providers only act on previously expressed wishes in an emergency situation when an SDM is not available to provide consent.
- Health Care Providers require informed consent prior to initiating treatments.

Resources

Advocacy Centre for the Elderly (ACE)

- Health Care Consent and Advance Care Planning: Fairly Good Law and Good Intent, but Not Always Good Practice (2013)
- Admission to Long-Term Care Homes: are Evaluations of Capacity being conducted in Accordance with the Law? (2010)
- Advance Care Planning and End of Life Decision-Making: More than just Documents (2009)
- Consent, Capacity and Substitute Decision Making – The Basics (2009)
- 25 Common Misconceptions about the Substitute Decisions Act and the Health Care Consent Act (2008)
- Substitute Decision-Makers for Health Care Matters (2008)
- Who Assesses Capacity Under What Circumstances? (2008)
- Making Treatment Decisions (2006)

WEBSITE:

http://www.advocacycentreelderly.org/consent_and_capacity_-_publications.php

Resources

College of Nurses Ontario

This practice guideline on *Consent* provides an overview of the steps needed to obtain consent along with the *Guideline for Nurses Advocating for Clients Found Incapable of Making Certain Decisions.*

Available from:

http://www.cno.org/Global/docs/policy/41020_consent.pdf

Resources

Developed for social workers and social service workers who encounter dilemmas pertaining to consent and confidentiality with clients who are children and youth.

Practice Guidelines: Consent and Confidentiality with Children and Youth

Available from:
http://www.ocswssw.org/docs/childrenyouthguidelines.pdf

Code of Ethics and Standards of Practice (pgs. 43-45)

Available from:

http://www.ocswssw.org/docs/codeofethicsstandardsofpractice.pdf?LanguageID=EN-US

Resources

College of Physicians and Surgeons - Consent to Medical Treatment policy #4-05

The document helps clarify when and how a physician can obtain a patient's consent to treatment and what constitutes consent.

Available from:

http://www.cpso.on.ca/uploadedFiles/policies/policies/policyitems/Consent.pdf

Resources

Tool on Capacity and Consent - created by Advocacy Centre for the Elderly (ACE) and National Initiative for the Care of the Elderly (NICE)

Available from:

http://www.nicenet.ca/files/Capacity.pdf

Resources

A Guide to Advance Care Planning

http://www.seniors.gov.on.ca/en/advancedcare/index.php

Resources

Powers of Attorney (personal care and property)

http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/poa.pdf

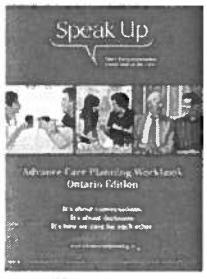
Resources

National Speak Up Campaign

Web site and resources for:

- Patients and families
- Professionals
- Community organizations / agencies / programs
- Researchers

* Resources posted on this site are not necessarily Ontario specific. Please consider this when using the site.



www.advancecareplanning.ca

ACP References- re: slide 30

Detering KM, Hancock AD, Reade MC & Silvester W. (2010). The impact of advance care planning on end of elderly patients: randomised controlled trial. *BMJ; 340*:c1345

Harle, L., et al. Advance Care Planning with Cancer Patients: Evidentiary Base and Guideline Recommendations. Evidence-Based Series #19-1. Toronto: Program in Evidence-Based Care: A Cancer Care Ontario Program. 2008. http://www.cancercare.on.ca/pdf/pebc19-1f.pdf

Ipsos Reid Poll, 2012 retrieved on December 17, 2012 from: www.advancecareplanning.ca/news-room/national-ipsos-reid-poll-indicates-majority-of-canadians-haven't-talked-about-their-wishes-for-care.aspx

Wright, AA., et al. (2008). Associations between end-of-life discussions and health care expenditures. *JAMA. 300* (14):1665-1673

Zhang, B., et al. (2009). Health care costs in the last week of life. *Arch Intern; 169* (3): 480-488

Questions???