

Consent to Medical Treatment - Patient Information

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Summary Requirements for the provision of information to patients and obtaining consent to medical treatment. Note: Minor errors identified in the Substitute Consent form appended to this policy directive have been corrected and advised by Information Bulletin IB2005_054.

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Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations - Non Declared, Community Health Centres, Dental Schools and Clinics, NSW Ambulance Service, NSW Dept of Health, Public Health Units, Public Hospitals

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Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

CIRCULAR

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PATIENT INFORMATION AND CONSENT TO MEDICAL TREATMENT

This circular supercedes Circular 99/16. Patient matters manual also refers.

Introduction

This Circular contains NSW Health's policy for the provision of information to patients and consent to medical treatment. The Circular emphasises the importance of ensuring that patients are provided with adequate information to enable them to make informed decisions as to whether to undergo medical or other treatment in health organisations. The Circular is designed to foster the improved provision of information to patients to enable them to make informed decisions regarding treatment and to assist medical practitioners to discharge their legal obligations.

Mandatory Policy

Compliance with this policy is mandatory.

Application

This Circular applies to all public health organisations(Area Health Services, Statutory Health Corporations and Affiliated Health Corporations in respect of their recognised establishments and recognised services). The Circular also applies to all people who work within these organisations and are involved in the provision of health care, including employees, contractors and other health service providers. The policy and procedures in this Circular apply to people whose employment is part time, temporary, contractual, casual or short term.

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In accordance with the provisions incorporated in the Accounts and Audit Determination, the Board of Directors, Chief Executive Officers and their equivalents, within a public health organisation, shall be held responsible for ensuring the observance of Departmental policy (including circulars and procedure manuals) as issued by the Minister and the Director-General of the Department of Health.

Main Points

The Department released Circular 99/16 – Patient Information and Consent to Medical Treatment in March 1999. This Circular updates that policy. In particular, the following changes have been made:

- The Circular allows local policies to be developed for the administration of blood products by nursing staff, where certain conditions are met. This is to overcome difficulties in remote areas where a hospital may not have medical officers immediately available at the time a blood transfusion is required.
- The revised Circular provides additional detail on procedure to follow where conflicts arise between minors and their parent/s guardians in relation to consent for treatment for the minor.
- The revised Circular also includes new sections on issues such as refusal of treatment, Advance Care Directives, consent for treatment provided by Nurse Practitioners, delegation of consent and consent for the use of tissue removed during surgery to be used for other purposes, such as research.
- New Request/Consent Forms are attached which should be adopted by all public health organisations as soon as practicable. The Forms have been amended to comply with requirements of the Human Tissue Act 1983.

Consultation

All Area Health Services were consulted. Consultation also took place with the Department of Community Services, the NSW Guardianship Tribunal, The Royal College of Medical Administrators, the Medical Services Committee, the AMA, the NSW Nurses Association, the College of Nursing, The Royal Australasian College of Pathologists, the Australian and NZ College of Anaesthetists, ICE, Health Ethics Branch, Aboriginal Health Branch, and others.

Robyn Kruk
Director-General

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**NEW SOUTH WALES HEALTH DEPARTMENT
PATIENT INFORMATION AND CONSENT TO MEDICAL TREATMENT**

A: HOW TO OBTAIN CONSENT

1. *Why is it necessary to obtain patient consent?*

As a general rule, no operation, procedure or treatment may be undertaken without the consent of the patient, if the patient is a competent adult. Adequately informing patients and obtaining consent in regard to an operation, procedure or treatment is both a specific legal requirement and an accepted part of good medical practice. The NSW Health Patient Charter also contains a commitment to patients that public health organisations will clearly explain proposed treatment including significant risks and alternatives in a way patients can understand and obtain patient consent before treatment, except in an emergency or where the law says patients must have treatment.

Consent to the general nature of a proposed operation, procedure, or treatment must be obtained from a patient. Failure to do this could result in legal action for assault and battery against a practitioner who performs the procedure.

The obligation to obtain consent is distinct from the obligation disclose information to a patient and warn a patient of material risks.

2. *Why is it necessary to warn a patient about material risks?*

As a general rule, all patients have a choice as to whether or not to undergo a proposed procedure, operation or treatment. Whilst a patient might consent to a procedure once he or she has been informed in broad terms of the nature of the procedure, this consent will not amount to the exercise of choice unless it is made on the basis of relevant information and advice.

Patients must also be provided with sufficient information about the condition, investigation options, treatment options, benefits, possible adverse effects or complications, and the likely result if treatment is not undertaken, in order to be able to make their own decision about undergoing an operation, procedure or treatment.

A medical practitioner has a legal duty to warn a patient of a material risk inherent in the proposed treatment. What amounts to a material risk is explained in section 7. Failure to do this may be a breach of the practitioner's duty of care to the patient and could give rise to legal action for negligence.

Patients have a legal right to refuse treatment. This is discussed in section 6. Consent of the patient is therefore required to be obtained in nearly all cases.

3. *When is the consent of the patient not required or when do different arrangements apply to obtaining consent?*

There are a number of exceptions to the general rule that the consent of a patient must be obtained before commencing treatment. In some cases, consent from another authority or person may be required before treatment can proceed. The circumstances where consent is not required or a different arrangement applies for seeking consent are as follows:

- a. Consent is not required where immediate treatment is necessary to save an adult person's life or to prevent serious injury to an adult person's health where the person is unable to consent, subject to there being no unequivocal written direction by the patient to the contrary (See section 22).
- b. Except in the above emergency situation where a person aged sixteen years or

over is unable to consent, a guardian, a “person responsible” or the Guardianship Tribunal may be authorised to give consent on behalf of the patient in accordance with the provisions of the *Guardianship Act 1987*. In limited circumstances, minor treatment may proceed without the need to obtain consent (although specific requirements must be met). The requirements for determining whether a person is unable to consent are set out in section 21 of this Circular. The requirements for seeking a ‘substitute’ consent or proceeding without consent are set out in Attachment A.

- c. Specific arrangements apply for the obtaining of consent from a parent or guardian of a child patient. The arrangements for seeking consents are outlined in section 25.
- d. Pursuant to section 174 of the *Children and Young Persons (Care and Protection) Act 1998*, consent is not required to treat a child or young person if treatment is required urgently to save the life, or prevent serious damage to the health of the child or young person (see section 25).
- e. Consent of the patient is not required for treatment which is authorised by an order of a Court, for example, an order of the Supreme Court for specific treatment of a minor.
- f. Some procedures authorised by statute may proceed without consent, eg compulsory blood drug and alcohol estimation on the request of a police officer.
- g. Specific methods and forms of consent are provided under the Mental Health Act for patients receiving ECT or psychosurgery and for treatment provided to an involuntary patient. (See section 23)

4. Does “written” consent need to be obtained?

Generally, the law does not require consent or the provision of information, including warnings about material risks, to be documented in writing. (Exceptions to this general rule include some consents obtained under the *Guardianship Act 1987*.) Indeed, patient consent can be “express”, either orally or in writing, or it can be “implied” from a person’s conduct, for example a patient may hold out their arm to receive an injection. Irrespective of whether the consent is obtained orally or is documented in writing, a consent will only be valid where it satisfies the requirements outlined in section 5 of this Circular. Consent documented in writing is only as valid as the consent it represents.

However, consent obtained in writing will assist practitioners in any subsequent legal proceedings as it will support their view that the treatment has been discussed with the patient and that consent has been obtained. The absence of a consent form could give rise to the implication that the procedure has not been discussed or that consent has not been obtained. The use of an adequate consent form will also assist practitioners in providing appropriate and adequate information to their patients under their care in line with community expectations and legal requirements.

It is the Department’s policy that written consent using the attached model consent form is to be sought for major procedures including:

- (i) all operations or procedures requiring general, spinal, epidural, or regional anaesthesia or intravenous sedation;
- (ii) any invasive procedure or treatment where there are known significant risks or complications;
- (iii) blood transfusions or the administration of blood products;

- (iv) experimental treatment for which the approval of an ethics committee is required (unless there are sound reasons for doing otherwise).

Abbreviations should not be used on consent forms.

The consent form should remain a separate 'stand alone' form and form part of the patient's clinical record. This should not be read as preventing consent forms from being printed on the reverse side of admission forms, or from being published as part of an admission booklet. It is essential however that the patient information and consent processes be given adequate emphasis when admission decisions are made. Where the consent form is published as part of an admission booklet, the relevant sections of the form must not be separated.

Signed consent forms are not required for minor procedures performed under local anaesthesia, eg insertion of IV cannulae, urethral catheterisation, or suture of minor lacerations. However, ***the criteria for obtaining a valid consent must still be met***, the procedure must still be explained to the patient and it is advisable for a written note to be made in the patient's medical records to this effect.

If the consent is provided orally, or is implied (ie by body language), the procedure must still be explained to the patient and it is advisable for a written note to be made in the patient's medical records indicating that they consented to treatment and how they consented. If there is a particular reason why consent was not obtained in writing, this should also be documented.

5. What are the requirements for obtaining a 'valid' consent?

For a patient's consent to be valid a number of criteria will need to be met.

First, the person must have the capacity to give consent, that is, the person must be able to understand the implications of having the treatment. Some examples of where patients are not considered as having this capacity include: a child under the age of fourteen, some people affected by mental illness, and some people who are affected by dementia, brain damage or intellectual disability, and some people who are temporarily or permanently impaired by drugs or alcohol. As noted above, where a patient is found to be lacking in capacity, there may be alternatives to obtaining consent. These are addressed later in this document.

A patient who is not fluent in English, is deaf or has other special communication needs does not lack capacity to make decisions, unless another factor, such as those listed above, is also present.

The second requirement is that consent must be freely given. The patient must not be pressured into giving consent. This would include pressure from hospital staff, a medical practitioner or family. Pressuring a patient into making a quick decision could be considered coercion.

Thirdly, the consent must be specific, and is valid only in relation to the treatment or procedure for which the patient has been informed and has agreed to. Medical practitioners need to be aware that there is legal precedent whereby practitioners have been found liable for damages for trespass to the person if, when performing a procedure for which consent has been obtained, they undertake an additional procedure without obtaining specific consent for that procedure, even where the additional procedure appears desirable. Such specific consent is not required where during a procedure, further immediate treatment becomes necessary to save an adult person's life or to prevent serious injury to that person's health where that person is unable to consent.

Finally, the patient must be informed in broad terms of the procedure **which is intended**, in a way the patient can understand

These criteria must be met irrespective of whether the consent is obtained in writing or orally. The mere mechanical signing of a consent form is, of itself, of limited value. The requirements for obtaining a valid consent as outlined above must be met.

6. Can a patient refuse treatment?

A competent patient is entitled to refuse medical treatment. The High Court of Australia first articulated this principle in Marion's case, stating that a legally competent person has a right "to chose what occurs with respect to his or her own person."¹ For a competent patient, the right to refuse treatment exists, notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent. Treating a competent patient who has validly refused treatment could constitute an assault or battery.

Like consent to medical treatment, a refusal must be freely given, and be specific. As with consent, if the patient's circumstances change significantly, the refusal may not remain valid and may need to be confirmed.

A refusal can be express, implied or in writing, however, it is preferable that a refusal of treatment is recorded in writing and signed by the patient. Any discussions with patients about refusal of treatment should be recorded in detail in the medical record.

6.1 Pregnant patients

Australian law does not recognise a fetus as a separate legal entity until it is born alive. Therefore, legally, a competent pregnant woman has the right to make decisions about her own treatment.

Pursuant to section 25 of the *Children and Young Persons (Care and Protection) Act 1998*, a person who has reasonable grounds to suspect, before the birth of a child, that the child may be at risk of harm **after** his or her birth may make a report to the Director-General of the Department of Community Services. The intention of this section is to provide assistance and support to the pregnant woman to reduce the likelihood that her child, when born, will need to be placed in out-of-home care. The principle is that of supportive intervention rather than interference with the rights of pregnant women.

6.2 Refusal via Advance Care Directives

Health practitioners should not provide treatment or perform a procedure where there is an unequivocal written direction, such as an Advance Care Directive, by the patient that such treatment is not to be provided in the circumstances which now apply to the patient.

Advance Care Directives may not contain instructions for illegal activities, such as euthanasia.

Should a patient give such a written direction, the medical practitioner should consider whether it is specific enough to apply to the clinical circumstances which have arisen. Consideration should also be given to the currency of the advance care directive, and whether it appears to be made in contemplation of the current circumstances (for example, was it made after the

¹ *Secretary, Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218 – 58 (Marion's case).*

diagnosis of the current illness). Medical practitioners should also consider whether there is any reason to doubt the patient's competence at the time that the advance care directive was signed, or whether the patient was under undue pressure to make the directive. If the practitioner establishes that the refusal is invalid, or based on a false assumption or misinformation, s/he can treat the patient in accordance with his or her professional judgment of the patient's best interests.

Concerns may arise about the legality applicability of an advance care directive, especially where the patient refuses treatment considered to be usual medical practice, and /or where the refusal may be life threatening. In an emergency, the medical practitioner can treat the patient in accordance with his or her professional judgment of the patient's best interests, until legal advice can be obtained. Where there are concerns about an Advance Care Directive in a non-emergency situation, the medical practitioner may wish to consult with the patient's relatives, or those close to the patient, seek legal advice, discuss the issue with colleagues, or other clinicians involved in the patient's care. All discussions should be documented in the patient's medical record.

If a patient presents with an Advance Care Directive or other document that refuses treatment, a copy of the document should be made and placed on the patient's medical record.

Further information can be found in "*Using Advance Care Directives*"-
http://www.health.nsw.gov.au/pubs/2004/pdf/adcare_directive.pdf

7. How do I properly inform a patient about a procedure and warn of material risks?

In addition to meeting the requirements for obtaining a valid consent, the patient must be provided with sufficient and material information for there to be a genuine understanding of the nature of the operation, procedure or treatment. Failure to warn a patient about the material risks inherent in a proposed procedure is a breach of the medical practitioner's duty of care to the patient and could give rise to legal action for negligence.

The legal duty of practitioners to disclose information regarding treatment was defined by the High Court of Australia in the case of ***Rogers v. Whitaker (1992)***. The principles concerning the provision of information to patients have been developed by the courts with regard to the paramount consideration that a person is entitled to make their own decisions about their treatment.

Practitioners should give information about the 'material' risks of any intervention, especially those likely to influence a patient's decision. A risk is 'material' if, in the circumstances, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it, or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it (***Rogers v. Whitaker***). Known risks should therefore be disclosed when an adverse outcome is a common event though the detriment is slight, or when an outcome is severe even though its occurrence is rare. Further, practitioners should carefully consider whether knowing about a risk is likely to influence a patient's decision. In addition practitioners should carefully consider patients' reactions to specific risks, however unlikely those risks might be, particularly where specific concerns regarding adverse outcomes are raised, however unlikely.

8. What are the NHMRC guidelines for informing patients about the risks associated with medical treatment?

The National Health and Medical Research Council (NHMRC) in 1993 produced a set of guidelines for medical practitioners on providing information to patients which is largely in

accord with the findings in *Rogers V. Whitaker*.² The NSW Health Department strongly favours the use of the NHMRC guidelines by practitioners when informing patients on the risks associated with medical treatment. The NHMRC recommends that practitioners discuss:

- (i) the possible or likely nature of the illness;
- (ii) the proposed approach to investigation and treatment including:
 - what the proposed approach entails,
 - the expected benefits;
 - common side effects and material risks;
 - whether the procedure is conventional or experimental; and
 - who will undertake the intervention.
- (iii) other options for diagnosis and treatment;
- (iv) the degree of uncertainty of the diagnosis and any therapeutic outcome;
- (v) the likely outcome of not having the diagnostic procedure or treatment, or of not having any procedure or treatment at all;
- (vi) any significant long term physical, emotional, mental, social, sexual, or other outcome which may be associated with the proposed intervention; and
- (vii) the time and cost involved including any out of pocket expenses.

The NHMRC guidelines note that a practitioner's judgment about how to convey risks will be influenced by a number of factors. These include: the seriousness of the patient's condition, the nature of the intervention (complex interventions require more information); the likelihood of harm and the degree of possible harm; the questions asked by the patient; the patient's temperament, attitude and level of understanding (including literacy and intelligence level); and accepted medical practice. Information should be provided in a form and manner which helps patients to understand the problem and the treatment options available, and which is appropriate to the patient's circumstances.

9. Can a patient information form, brochure or other material about a treatment be used to inform a patient when obtaining consent?

Pre-prepared material (translated where relevant) about a procedure or treatment may be useful if given to the patient as a means of stimulating discussion and for guiding the medical practitioner when informing the patient. However pre-prepared material should not be used as a substitute for ascertaining whether a person understands the nature of, and risks involved in, the procedure or treatment, as the provision of the pre-prepared material alone will not discharge the legal duty in most cases. The practitioner should assist the patient to understand the material and explain any information that the patient finds unclear. The practitioner must give the patient an opportunity to read the material and raise any specific issues of concern either at the time the information is given to the patient or subsequently.

The practitioner informing a patient must consider that individual patient's circumstances. This can be done by considering any personal knowledge of the patient, their prior medical history and other issues directly raised by the patient. The practitioner will also need to consider whether pre-prepared material is up to date, accurate and appropriate for the patient.

It is essential that patient information material discloses all "material risks", at least in general

² NHMRC General Guidelines for Medical Practitioners on Providing Information to Patients, Canberra: Commonwealth of Australia June 1993. As at August 2004, these guidelines were under review. They can be accessed at <http://www.health.gov.au/nhmrc>

terms. The more likely the risk the more specific the detail that should be provided. An inadequate or inaccurate information sheet could have significant implications in subsequent litigation because it could be inferred the patient has not been properly informed. It must be emphasised that since a patient's reactions and views plays an important part in determining what "material risks" should be disclosed, an information form cannot be a substitute for a full and frank discussion with the patient. Any additional information provided should be specifically noted on the information sheet by hand. The NHMRC guidelines on the provision of information to patients should be followed as a guide to the information that must be provided in preparing such material. Such material should be regularly reviewed to ensure it remains accurate.

10. What if the person is from a non-English speaking background?

To ensure that a valid consent is obtained, interpreters should be used for any non-English speaking patients in accordance with the Department's current policy on the use of interpreters (see Circular 94/10).

A professional interpreter should be present to ensure patient consent and understanding when a recommendation for surgery, treatment or research is communicated to a non-English speaking patient.

The consent form signed by a non-English speaking patient must contain a statement signed by the Interpreter that he/she has interpreted the content of the form and all the information supplied by the treating practitioner to the patient.

Consent for treatment may not be valid if it is obtained through a child or family members other patients, visitors or non-accredited staff acting as interpreters.

11. Can information be withheld from the patient?

The circumstances in which information can be withheld from the patient are limited. The withholding of information on the grounds of 'therapeutic privilege' denies the patient the right to participate in decision making. The scope of the privilege is uncertain and the discretion to exercise 'therapeutic privilege' should only be used in very limited cases having regard to the basic legal rights of patients to make decisions about their own medical treatment and uncertainty surrounding the scope of the 'privilege'. Consideration should be given to consultation with other colleagues before such a decision is made.

The only situations where the duty to inform can be breached are as follows.

- (i) The patient expressly directs the practitioner to make the decisions, and does not want the offered information. Even in this case the practitioner should give the patient basic information about the diagnosis and treatment.
- (ii) The practitioner may exercise "therapeutic privilege," that is the practitioner can withhold information if they hold a reasonable belief that disclosure of a risk would prove damaging to the patient's health. To withhold information in these circumstances, the practitioner would need to make a judgment, on reasonable grounds, that the patient's physical or mental health might be seriously harmed by the information. The types of factors governing therapeutic privilege include the patient's personality, temperament or attitude; their level of understanding; the nature of the treatment and the likelihood of adverse effects resulting from the treatment.

Information cannot be withheld from substitute decision makers appointed pursuant to the Guardianship Act. Therapeutic privilege is not recognised by the Guardianship Act as a ground for failing to provide information to the person responsible. If, for some reason, information cannot be provided to the person responsible, consent to the treatment should be sought from the Guardianship Tribunal.

12 Does 'written' consent need to be obtained for every procedure or step in a 'treatment program'?

Some treatments involve a number of separate procedures or the administration of medication or blood products over a period of time or a series of patient visits. Chemotherapy and the administration of blood products to patients with haemophilia are examples where this may be the case.

Where such a treatment program is proposed, the patient should be provided with information and advice about the procedure, including advice about the material risks and consent should be obtained and documented, in the normal fashion prior to beginning treatment. An explanation of the treatment program, the steps or separate treatments/procedures involved and the 'material' risks associated with the treatment program should be provided. Generally a form documenting that this has occurred for each stage of the treatment program will generally not be necessary as patient consent can be implied from continuing conduct.

However, a new form should be completed if a new treatment is proposed which was not previously explained to the patient, where alternative treatments become available or if new risks associated with the treatment are identified. Medical officers and hospital staff should remain alert to any issues or concerns raised by the patient during the treatment program. Before continuing with the treatment program, such concerns should be discussed with the patient and documented in the patient's medical record. If the issues raised are significant, a 'new' form should be completed.

13. Can a consent form be faxed?

A consent form constitutes evidence that a patient has consented to a procedure and has been provided with relevant information and is important in protecting the hospital and attending medical officer from certain legal liabilities. It is the Department's view that an original consent form is preferable to a faxed or photocopied form and that originals should always be obtained where possible. If it is not possible to obtain an original consent form, the reasons why the original could not be obtained should be noted in the patient's medical record. When faxing or photocopying consent forms, special care should be taken to ensure that double sided documents are transmitted or copied in their entirety.

14. For how long does consent remain valid?

The general rule is that consent will remain valid until it is withdrawn by the patient or until the patient's circumstances change in a material respect.

Hospitals and practitioners should bear in mind, however, that a change in patient's circumstances could encompass a number of situations. This would include a change in the patient's condition which would affect treatment, the development of alternative treatments to the recommended procedure or the identification of new risks or side effects associated with the recommended procedure.

It is suggested, therefore, that a new consent form be obtained or the patient be asked to affirm their previous consent if a significant period of time has lapsed since the original consent was obtained. What constitutes a "significant amount of time" will depend on the individual circumstances of the case.

B: WHO SHOULD OBTAIN CONSENT

15. *Who is legally responsible for ensuring a patient has the necessary information and advice and for obtaining consent?*

A practitioner who performs a procedure, operation or **treatment without obtaining consent** may be liable in an action for assault and battery. This does not mean the practitioner cannot ask another practitioner to seek consent on their behalf, although they should be aware they could still be held responsible if a valid consent has not been obtained.

Where a practitioner recommends or advises that a patient undergo an operation, procedure or treatment, they will be responsible for ensuring they provide sufficient, appropriate and relevant **information and advice** to enable the patient to make their own decision to undergo the operation, procedure or treatment. Once again, this does not mean that they cannot have another person undertake that task, although they may be held responsible in some circumstances if this is not done properly.

In general, the attending medical officer (AMO) under whose care a patient is admitted either as a private or a public patient will have, or may share, legal responsibility for the overall care of the patient. Health services and hospitals also may have legal responsibilities in this area, depending on the circumstances of the individual patient. For many of the patients admitted under its care, the hospital may have certain duties, including a duty to take reasonable steps to ensure that consent has been obtained.

In many cases, the AMO who recommends a procedure may not perform the procedure. This is likely to arise in two main situations: (i) For patients who are not admitted as private patients of a particular practitioner, the task of performing a procedure may be delegated in accordance with hospital protocol to a hospital staff member by the AMO under whose care the patient is admitted; and (ii) Certain major radiological procedures, invasive investigations and some operations are often initiated by the primary AMO but are performed by another medical practitioner, radiologist, physician or surgeon. Practitioners should be aware that even though the AMO will not be performing the procedure, both the AMO and the practitioner performing the procedure (or providing advice to a patient) will have legal and professional responsibilities to the patient in regard to the provision of information and advice and to ensure consent has been sought.

16. *Can information be provided to a patient or consent obtained by another practitioner on my behalf?*

To ensure that hospitals' resources are utilised appropriately and that treating practitioners are able to manage their time effectively, arrangements may be put in place to delegate the task of providing the necessary information to patients to enable them to make a decision to undergo a treatment and for seeking consent. The arrangements set out below have been developed having regard to: the respective legal obligations of hospitals (independently and through its staff) and AMOs arising from the admission status of patients; the rights and expectations of patients; and the appropriate use of practitioner time and hospital resources.

These arrangements apply where consent is required to be documented in writing in accordance with this policy.

Where the task of informing the patient and seeking consent has been delegated, the AMO must be satisfied that the practitioner is competent to undertake that task and, in appropriate cases, take reasonable steps to ensure that the patient has been properly informed and that a consent form has been completed. However the AMO should be aware that the practitioner performing the task will also have legal and professional responsibilities to provide all necessary and proper information to assist the patient in making a decision and for obtaining a valid consent. Senior practitioners should be aware that more junior practitioners have a

responsibility to refuse to undertake the task if they do not consider they have sufficient skill or experience. Decisions made by junior staff in this regard must be respected. The medical practitioner performing the procedure cannot always assume that someone else has properly informed the patient and obtained a valid consent. Therefore, the medical practitioner performing the procedure should verbally confirm that the patient understands the procedure and that the material risks have been discussed prior to the procedure commencing.

It is the Department's policy that every public patient should know which practitioner the hospital has arranged to be primarily responsible for their care. The issue of which practitioner will be performing the procedure should be canvassed with the patient at the time of providing information to the patient and obtaining consent. Public patients should be advised accordingly where the doctor who is to perform the procedure has not yet been nominated.

17. Who may obtain patient consent and when should it be obtained?

17.1 Admission from a practitioner's private rooms

It is the Department's policy that prior to admission to a public hospital, a patient who is seen by an AMO in their private rooms should be provided with the necessary information about the procedure, including information about the material risks involved, in the AMO's rooms. The AMO should also satisfy themselves as to the other requirements for obtaining a valid consent, as outlined in section 5. The relevant sections of the consent form should be completed by the AMO and the form provided to the patient. The patient can give consent and complete the form either at the same time or prior to admission into hospital. This arrangement will apply irrespective of whether the patient is to be admitted as a public or private patient. However, the following points should be noted.

- (i) In some cases it may be necessary for information about the procedure to be provided to the patient and for the consent to be obtained in the practitioners rooms, for example where an interpreter has been in attendance. In such cases the form may need to be completed by the patient in the rooms. Where this occurs care should be taken to ensure that the patient is not pressured or rushed into signing the form as such consent of the patient will not be valid. (See the requirements for obtaining a valid consent in part 5.)
- (ii) In all cases where the patient wishes to have more time to consider the proposed treatment, the AMO should sign the relevant parts of the form and provide the form to the patient who can subsequently complete the consent form. In such cases, the patient should be made aware that admission to the hospital will be conditional on production of a completed consent form.
- (iii) Admissions staff should be aware that on occasions, admission may be arranged through an AMO's private rooms, without the patient having been seen there. This situation is likely to arise in the case of recurring conditions or long term treatment programmes. Where this reasonably appears to be the case, the provision of information to the patient and the seeking of consent from the patient should be arranged in accordance with the procedures outlined below for patients that present to the hospital.
- (iv) An AMO may provide the necessary information to a patient and seek consent in their rooms for a procedure that will be carried out by, or that will require the involvement of, another practitioner. In light of the nature of and risks involved with the procedure, the AMO should consider whether an additional consultation with the other proceduralist should be arranged. A common example of this may be where the risks of anesthesia need to be explained separately by the attending anesthetist.

17.2 Admission through the hospital Emergency or Outpatients Department

Where a patient presents to the hospital for treatment and is to be admitted through Emergency, the AMO should inform the patient, seek consent and complete the consent form at the pre-operative consultation. The necessary information should be provided and a valid consent should be obtained and documented prior to any pre-operative medication being given, and prior to the operation, procedure or treatment. The tasks may be delegated in the following circumstances:

- (i) Where the patient is to be admitted as a public patient, and the AMO is to perform the procedure, registrars and resident medical officers may be delegated the task of informing a patient and obtaining consent where:
 - (a) it is not possible for the AMO to obtain consent personally;
 - (b) the delegated practitioner does not object to undertaking the task; and
 - (c) the AMO is satisfied that the delegated practitioner has the necessary skills and experience to inform the patient so as to discharge the respective legal obligations of the AMO and the hospital.
- (ii) Where the patient is to be admitted as a public patient and the performance of a procedure or treatment has been delegated to a registrar or resident by the AMO, that staff member may obtain consent where the AMO is satisfied that the delegated practitioner has the necessary skills and experience to inform the patient.
- (iii) Where the patient is to be admitted as a private patient - As the AMO will ordinarily provide the necessary information, including information about material risks, and obtain consent from a patient who elects to be admitted as a private patient of the AMO, hospital staff will not be required to be involved in the provision of such information or in obtaining consent from such patients. AMOs should ensure they are available to seek patient consent for their private patients prior to the administration of pre-medication. In exceptional circumstances senior experienced hospital medical staff may be required to seek consent from private patients of an AMO where:
 - (a) the AMO is unable to obtain consent personally; and
 - (b) the procedure is required as a matter of urgency; and
 - (c) the delegated practitioner does not object to undertaking the task; and
 - (d) the AMO is satisfied that the delegated practitioner has the necessary skills and experience to inform the patient so as to discharge the legal obligations of the AMO.

Out-patients being booked for elective procedures/treatments may be informed by a registrar who shall complete the patient consent form and ensure that patient consent is given. Such patients should be advised by the registrar that they will not necessarily be carrying out the procedure when the patient is admitted.

Interns are not to be delegated the task of seeking consent and informing the patient for operations or procedures unless the AMO is satisfied, in addition to the requirements outlined above at 17.1 (i), that: the procedure is a minor procedure; and the intern has, under the supervision of a senior experienced practitioner, undertaken and discharged in a competent manner the task of informing a patient with the same condition or similar circumstances. This does not prevent an intern from having a form completed in the circumstances outlined in the next paragraph.

18. What is the role of other nurses and other health professionals in providing information and obtaining consent for procedures that are performed by medical staff?

Administrative and nursing staff cannot be delegated the task of informing a patient about the material risks of an operation, procedure or treatment and obtaining consent, where consent is required to be documented in writing in accordance with this policy. However in some cases, an AMO may inform the patient and obtain verbal consent and subsequently ask a hospital staff member to have the patient complete the form. (Note that the AMO is still required to complete the "Provision of Information to Patient " or "Medical Advice" section of the form.) While this practice should not be encouraged, it is recognised this may be necessary in some circumstances. In these situations the staff member is not seeking the consent, they are simply having the patient confirm their prior consent. Any outstanding issues of concern to the patient should be brought to the attention of the AMO.

Many other procedures are performed in hospitals which are not performed by medical practitioners. In most cases, consent will be implied from the patient acquiescing to the procedure.

19. What is the role of other nurses and other health professionals in providing information for procedures?

Patients may seek advice from another medical practitioner, nurse or other health care professionals regarding the nature of a treatment, operation or procedure. All health care professionals need to be aware they are under a general duty to exercise reasonable care where they provide any advice or information to a patient. All practitioners, including nurses, are responsible for the advice they give to patients.

In circumstances where information is sought from a health care professional who is not the practitioner responsible for ensuring that the patient is appropriately informed about a procedure and seeking consent, the health care professional should ensure that any additional advice is accurate and *documented in the patient's record*. If a health care professional becomes concerned that the patient lacks a sufficient understanding about the procedure, operation or treatment to have made a valid decision to undergo that operation, procedure or treatment, the health professional should take reasonable steps to ensure the person receives the necessary additional information from the treating practitioner.

20. Can nurse practitioners obtain consent for the treatment they perform?

Nurse practitioners are registered nurses working at an advanced practice level. They are authorised by the Nurses Registration Board of New South Wales to use the title 'nurse practitioner'.

Authorised nurse practitioners may initiate medications, order diagnostic tests and make referrals only when they are operating within guidelines approved by the Director-General. Nurse practitioners have the same obligations as do medical practitioners, when obtaining consent for the procedures which they are authorised to perform.

C: PATIENTS WHO ARE INCAPABLE OF GIVING CONSENT

21. *When is a person incapable of giving consent?*

A person is incapable of giving consent if they are not “competent”. There is no single legal test or definition of competency. However, in order to be competent to consent to or refuse treatment, a patient must be able to comprehend and retain treatment information and consider the information in order to reach a decision. At determination of competency is a determination of the particular patient’s capacity to perform a particular decision-making task at a particular time. It is possible that a patient could be competent to make some, but not all decisions concerning their treatment.

A patient may lack competency due to a number of reasons. These include:

- Temporary factors such as the patient’s medical condition (i.e. unconsciousness) (For treatment in an emergency, see section 23);
- Mental illness (See section 24);
- Intellectual impairment, dementia, or brain damage (See Attachment A);
- A child aged 14 or less (See section 25).

The Guardianship Act provides methods for obtaining consent to treat those persons aged **16** years or over who are incapable of giving consent. A person is incapable of giving consent, within the meaning of that Act, where the person is incapable of understanding the general nature and effect of the proposed treatment, or is incapable of indicating whether or not the patient consents to the treatment. A summary of relevant provisions is provided at **Attachment A**.

The Department is aware that in some instances a patient will have been administered pre-medication without a consent form having been completed. All hospitals **should adopt procedures to prevent this situation from** occurring. However if such a situation arises, staff should be aware that the absence of a signed form does not prevent the procedure from proceeding provided that a valid verbal consent was previously obtained and the patient had been provided with sufficient information. If the AMO is satisfied that this has occurred, such a procedure may proceed. Of course, this should be documented in the medical record.

22. *Is the consent of a patient’s spouse required for any procedure?*

Where the patient is capable of giving consent, there is no specific requirement to obtain the consent of the spouse (or any other family member) and this should only be done with the specific authority of the patient.

If a person is 16 years of age or over and incapable of giving consent, the provisions of the Guardianship Act 1987 will apply and the consent of the patient’s “person responsible” will be required (unless consent is not required, or the consent of the Tribunal is necessary). (See Attachment A)

The person responsible for a patient will often be the patient’s spouse. Spouse includes husband or wife or de facto, and can include a same sex de facto.

23. What if treatment is urgently required but the person is incapable of giving consent?

In an emergency, where the patient is unable to give consent and the treatment is required immediately:

- (i) to save the person's life; or
- (ii) to prevent serious injury to a person's health; or
- (iii) except in the case of special medical treatment, - to prevent the patient from suffering or continuing to suffer significant pain or distress;

the procedure/treatment may be carried out in the absence of consent. See Attachment A for further information concerning 'special medical treatment'.

Legal authority suggests that a medical practitioner should not provide treatment or perform a procedure in an emergency where there is an unequivocal written direction by the patient that such treatment is not to be provided in any circumstances. Should a patient give such a written direction, a medical practitioner should take reasonable steps to ascertain the true scope of the patient's refusal to consent and whether the patient had the capacity to decide at the time the direction was signed. In such a case, if the medical practitioner establishes that the patient's refusal was invalid or if the patient lacked the capacity to give the direction, the medical practitioner can treat the patient in accordance with his or her professional judgment of the patient's best interests. The circumstances surrounding an event of this sort should be carefully documented. See section 6 for further information on refusal of treatment and Advance Care Directives.

24. What if the patient involved is affected by a mental illness?

If a voluntary patient does not have the capacity to consent due to mental illness, the substitute consent provisions of the Guardianship Act will apply (See Attachment A).

The remainder of this section relates to the treatment of patients under the Mental Health Act.

24.1 Emergency Surgery

A medical superintendent can consent to emergency surgery on behalf of an involuntary patient suffering from a mental illness, if, in the medical superintendent's opinion, the patient is incapable of giving consent, or is capable of giving consent and refuses to do so, or neither gives nor refuses consent and the surgery is necessary, as a matter of urgency, in order to save the life of the patient or to prevent serious danger to the health of the patient.

A medical superintendent can consent to emergency surgery on behalf of a voluntary patient or a forensic patient not suffering from mental illness, if in the medical superintendent's opinion, the patient is incapable of giving consent, and the surgery is necessary, as a matter of urgency, in order to save the life of the patient or to prevent serious danger to the health of the patient.

Consent given by a medical superintendent should be in writing and signed.

In this section, references to a medical superintendent also include a deputy medical superintendent, responsible medical officer or authorised officer.

24.2 Operations and Treatment other than Emergency Treatment

A medical superintendent may apply to the Mental Health Review Tribunal, or to an authorised officer, for consent to perform a surgical operation or special medical treatment (see below) on

a temporary patient, continued treatment patient, forensic patient (suffering from mental illness) or any other patient detained in a hospital if, the patient is incapable of giving consent, or is capable of giving consent and refuses to do so, or neither gives nor refuses consent and the medical superintendent is of the opinion that the surgery or special treatment is desirable, having regard to the patient's interests.

A medical superintendent may apply to the Mental Health Review Tribunal or to an authorised officer, for consent to perform a surgical operation or special medical treatment on an informal patient or a forensic patient (not suffering from mental illness), if in the medical superintendent's opinion, the patient is incapable of giving consent, and the medical superintendent is of the opinion that the surgery or special treatment is desirable, having regard to the patient's interests.

Applications to perform surgical applications can only be made to the Tribunal, or to an authorised officer, 14 days after written notice of the intention to obtain consent from the Tribunal or the authorised officer, for the surgery, has been given to the patient's nearest relative.

In this section, references to a medical superintendent also include a deputy medical superintendent, responsible medical officer or authorised officer.

24.3 *Electro-Convulsive Therapy (ECT)*

ECT treatment cannot be given to involuntary patients without the consent of the Mental Health Review Tribunal. For further information on ECT treatment for involuntary patients see http://www.mhrt.nsw.gov.au/mhrt_ect.htm

24.4 *Special Medical Treatment*

Any treatment, procedure, operation or examination that is intended, or is reasonably likely, to render a patient permanently infertile cannot be provided to psychiatric patients unless the medical practitioner providing the treatment is of the opinion that the treatment is necessary in order to save the patients life, or prevent serious damage to the patients health, or the Mental Health Review Tribunal has consented to the treatment. This type of treatment cannot be performed on patients under the age of 16 years.

25. *What if the patient is a minor?*

25.1 *Emergency Treatment*

Pursuant to section 174 of the *Children and Young Persons (Care and Protection) Act 1998*, a medical practitioner may carry out medical treatment on a child (a person aged under 16 years) or young person (a person aged 16 or 17) without the consent of the child or young person or a parent of the child or young person, if the medical practitioner is of the opinion that it is necessary, as a matter of urgency, to carry out the treatment on the child or young person in order to save his or her life or to prevent serious damage to his or her health. This means that emergency medical treatment, and emergency first aid treatment (including any procedure, operation or examination) may be provided without the consent of the minor or a parent or guardian.

25.2 *Non-Emergency Treatment*

It is NSW Health policy that if the patient is under the age of 14 years, the consent of the parent or guardian is necessary.

A child aged 14 years and above may consent to their own treatment provided they adequately understand and appreciate the nature and consequences of the operation procedure or treatment. However, where the child is 14 or 15 years of age, it is prudent for practitioners or hospitals to also obtain the consent of the parent or guardian, unless the patient objects.

Generally, the age at which a young person is sufficiently mature to consent independently to medical treatment depends not only on their age but also on the seriousness of the treatment in question relative to their level of maturity. The health practitioner must decide on a case-by-case basis whether the young person has sufficient understanding and intelligence to enable him or her to fully understand what is proposed.

Pursuant to the *Minors (Property and Contracts) Act 1970*, if a minor aged 14 and above consents to their own medical treatment the minor cannot make a claim against the medical practitioner for assault or battery. Also, where medical treatment of a minor aged less than sixteen years is carried out with the consent of a parent or guardian of the minor, the minor cannot make a claim against the medical practitioner for assault or battery.

For patients 16 years or over, their own consent is sufficient.

Suggested procedure to follow where treatment is not urgent and consent is refused by either the parents of a minor, or a minor aged 14 or above.

1. Establish that there is no suitable alternative treatment available to which consent would be forthcoming;
2. Obtain a second medical opinion and discuss this with the parent(s) or guardian and/or patient;
3. Attempt to reach agreement by counseling and mediation with the family. These efforts should be documented;
4. If applicable, explain to the parent(s) and patient that although the treatment is not urgent at this stage, if it is not provided in a timely manner, the situation may become urgent. Explain how delay would affect the patient. Explain that in urgent circumstances, treatment can be provided without parental consent, or the consent of the patient, but that the PHO would prefer to provide the treatment now, with consent;
5. If the parents do not consent to treatment on behalf of their child, consider making a report to DOCS that the child is a child at risk. Parents should be told that the PHO intends to notify DOCS before the notification is made. Once DOCS receives a notification, it will appoint a case manager to investigate the situation. This may ultimately lead to a guardian being appointed to consent to the treatment in place of the parents;
6. As a last resort, a court order can be sought authorising the treatment.

Legal Branch, NSW Health, or the Department of Community Services can be contacted for advice at any stage in this process.

26. Who gives consent for a minor if their parents have separated?

The Family Law Act makes it clear that each parent has full responsibility for each of their children who is under 18. Parental responsibility is not affected by changes to relationships (ie if the parents separate). Each parent has the responsibility for their child's welfare, unless the Court has made an order stipulating that one parent has certain responsibilities to the exclusion of the other parent.

This means that the consent of either parent to their child's medical treatment is usually sufficient. There are two circumstances where the consent of either parent may not be sufficient:

1. Where no formal court orders have been made, and one parent consents and the other refuses. The best way of handling this situation is by counselling the parents and trying to reach agreement on what is in the child's best interests.
2. Where the Court has made an order stipulating that a particular parent has particular responsibilities, i.e. for health care decisions, in which case, consent will have to be obtained in accordance with that order.

The Court can make four types of parental orders. The four types are residence orders, contact orders, child maintenance orders and specific issues orders.

A residence order or specific issues may stipulate that one parent has sole responsibility for the child's day-to-day care welfare and development. If this type of order has been made, that parent will be the only parent that can consent to medical treatment.

If there is an arrangement for a child to live with one parent for part of the time and the other for part of the time, this is a residence order. Both parents would retain full parental authority for the child, however, the consent of either parent would be sufficient to authorise medical treatment.

If a specific issues order is made granting one parent the sole responsibility for health care decisions, that parent will be the only parent that can consent.

Health care workers should assume that either parent can consent (alone) unless a court order stipulating something different is brought to their attention.

27. *Can a parent or guardian of a minor delegate their responsibility for providing consent to another adult?*

Occasionally, a parent delegates their responsibility for consenting to medical treatment on behalf of their minor child, to another adult. This may occur for example, in relation to Aboriginal children, where an extended family member, rather than the child's mother or father, is responsible for giving consent on their behalf.

A parent or legal guardian can authorise another adult to consent to treatment on behalf of their minor child. Ideally, this delegation would be in writing. If a written delegation exists, a copy of it should be placed on the minor's medical record.

If the delegation was given verbally, it should be documented in the minor's medical record.

If a minor presents with an adult other than a parent, the attending medical officer should attempt to ascertain the adult's relationship to the child and whether the adult is the child's guardian. Where the adult does not appear to be the child's guardian, but bears some relationship to the child, and confirms that the parent/guardian is aware that they are accompanying the child, it is reasonable to assume that the parent or guardian has delegated responsibility to that person, unless there is any indication to the contrary (ie a previous objection by the parent to that person exercising any authority in relation to the child).

28. *What is 'special medical treatment' in relation to children?*

Practitioners should be aware that the *Children and Young Persons (Care and Protection) Act 1998* classes some procedures as “special medical treatment”. These procedures cannot be carried out on a child under 16 years unless:

- (i) the treatment is required as a matter of urgency to save the child's life or to prevent serious damage to the child's health; or
- (ii) if the treatment is described in paragraphs (a), (b) or (c) below, the Guardianship Tribunal consents to the treatment.

The definition of ‘special medical treatment’ under the *Children and Young Persons (Care and Protection) Act* is different from that which is used under the *Guardianship Act* (See Attachment A). The definition of ‘Special medical treatment’ under the *Children and Young Persons (Care and Protection) Act* includes the following:

- (a) procedures or treatments that are intended to remediate a life threatening condition intended or reasonably likely to have the effect of rendering the child permanently infertile,
- (b) any medical treatment that involves the administration of a long-acting injectable hormonal substance (such as medroxyprogesterone acetate in aqueous suspension) for the purpose of contraception or menstrual regulation,
- (c) any medical treatment in the nature of a vasectomy or tubal occlusion,
- (d) any medical treatment that involves the administration of a drug of addiction within the meaning of the *Poisons and Therapeutic Goods Act 1966* over a period or periods totalling more than 10 days in any period of 30 days, except for medical treatment in circumstances where the drug is administered in accordance with a written exemption granted, either generally or in a particular case, by the Director-General of the Department of Community Services on the written request of the Director-General of the Department of Health,
- (e) any medical treatment that involves an experimental procedure that does not conform to the document entitled *National Statement on Ethical Conduct in Research Involving Humans* published by the National Health and Medical Research Council in 1999,
- (f) any medical treatment that involves the administration of a psychotropic drug to a child in out-of-home care for the purpose of controlling his or her behaviour.

The *Guardianship Act* applies to adults who are unable to consent to their own treatment, however, the Guardianship Tribunal's consent is also required in order to provide some special medical treatment to children under 16, as set out above.

D: CONSENT FOR SPECIFIC TREATMENT / PROCEEDURES

29. Blood Transfusions

Section 4 of this Circular requires consent to be documented in writing for certain procedures. This includes the administration of a blood transfusion or the administration of blood products. Blood products includes red cells, white cells, platelets, albumin products, fresh frozen plasma, Anti-D Immunoglobulin, coagulation factors, autologous transfusions and any biologically derived products such as thrombin products.

Section 20 of the Circular provides that administrative and nursing staff cannot be delegated the task of informing a patient about the material risks of an operation, procedure or treatment and

obtaining consent, where consent is required to be documented in writing in accordance with this Circular. Taken together, these two parts require that consent must be obtained and a consent form must be completed by the attending medical officer, or a medical officer to whom that task is properly delegated in accordance with section 16 of the circular.

The provision of information to patients and the obtaining of a valid consent for blood transfusions should, whenever practicable, be documented using a consent form, except of course in emergency situations where the patient is unable to give a valid consent. These arrangements however, may not be practical in small rural hospitals where there are no resident medical staff. In some cases, it may not be practical for a medical practitioner to be present to provide the information to the patient, and obtain a completed consent form and instead, nursing staff are required to administer the transfusion. To address these practical problems where necessary, Area Health Services may develop local policies so that senior nursing staff administering a transfusion can provide the necessary information to patients, obtain a valid consent and complete the consent form.

In developing such policies, Area Health Services should have regard to the following:

1. A local policy may only be developed to be used in circumstances where there is no resident medical officer on duty.
2. The decision to recommend a blood transfusion or administer blood products to a patient must be made on a case by case basis. To ensure that the clinical need for such treatment is established, appropriate arrangements should be put in place so that such decisions are made by a medical officer who is fully informed of the clinical circumstances of the patient.
3. Area health services should provide, where necessary, additional training to senior nursing staff so that they can provide clinically relevant, and accurate information. The need for additional training as circumstances change should be considered.
4. Consideration should be given to developing patient information sheets in English and other languages to assist with the consent process. These should be reviewed on a regular basis

30. *Obstetric procedures*

Written consent is not required for a normal delivery. Should an operation such as a Caesarean section or a blood transfusion be required, the consent process as detailed should be completed, insofar as it is practicable to do so in the circumstances.

If implied or oral consent is given to a particular procedure, (such as the use of forceps) this should be noted in the patient's medical record. Discussions about alternatives and material risks should be documented in the record. It may be appropriate for practitioners to discuss these additional procedures during the term of the pregnancy.

31. *Anaesthetics*

Patients must be informed about the material risks associated with anaesthesia for their planned procedure. If alternative types of anaesthetic, eg regional or general, are commonly used for the procedure, these must also be discussed. Where alternatives exist, options should be outlined, together with their advantages and disadvantages. This information can be provided by an anaesthetist if a separate consultation occurs, or by the attending medical officer.

Section 17 .1(iv) states that the attending medical officer should consider whether a separate consultation with an anaesthetist is required, and if so, arrange for that separate consultation to take place.

Where an attending medical officer refers a patient for a separate anaesthetic consultation, the anaesthetist should have the patient sign a separate consent form in relation to the anaesthetic. The attending medical officer should make a note that the patient has been referred for a separate anaesthetic consultation.

This provision is not intended to infer that a separate anaesthetic consultation is generally required, however, where anaesthesia involves particularly high risks, an anaesthetist should explain these. Whether a consultation with an anaesthetist is appropriate is a decision for the attending medical officer exercising his or her professional judgment, in the circumstances of the particular case.

32. Autopsy and tissue donation

These matters are specifically covered by the Human Tissue Act 1983 and specific consent forms are provided for these situations under that Act. For detailed information see Circular 2004/1.

33. Use of tissue removed for the purposes of medical, surgical or dental treatment

The Human Tissue Act 1983 requires the written consent of a person if tissue removed from their body during medical, surgical or dental treatment is to be used for any medical, therapeutic or scientific purposes, other than the ongoing treatment of the patient. Tissue includes any organ, or part of a human body, and any substance, including blood, extracted from a part of the human body. If, for example, tissue is removed during medical treatment for diagnostic purposes, a separate consent for a pathological examination is not required. However, if a tumour removed from a person's body is to be retained, and used in the future for the education of students and other medical professionals, or for research or for quality assurance purposes, then the consent of the person from whom the tumour was removed is required before the tumour can be used for these other purposes.

If the person is a person who is a patient to whom the Part 5 of the Guardianship Act applies (ie the patient is 16 years of age or over and incapable of giving consent) their "person responsible" who is consenting to the medical, surgical or dental treatment may also consent to other uses of the tissue.

If the person is a child, the senior available next of kin may consent to the use of the child's tissue. The senior available next of kin are the child's parents, or if there are no parents available, the child's guardian. However, tissue removed from children who are in the care of the State may not be used for any other medical, therapeutic or scientific purposes.

Tissue removed during a medical, dental or surgical procedure may be retained for a period not exceeding 72 hours, if the tissue was removed from the person during a procedure performed as a matter of urgency in order to save the life of the person, or prevent serious damage to the health of the person (if the person was an emergency patient). This means that if the person is unable to consent to the procedure and the use of any tissue removed before the procedure takes place, they may consent to the use of the tissue removed within the 72 hours following the surgery. If the person is a child, or dies during the course of their treatment, a senior available next of kin may consent to the use of the deceased person's tissue. A separate form is available for this. (See Circular 2004/1).

However, if possible, it is best to obtain the consent of the person themselves, or their person responsible (as the case may be) prior to treatment taking place. Accordingly, the consent form allows a person to consent to the use of any tissue removed during their treatment, for medical, therapeutic or scientific purposes.

It is noted that this applies only to tissue which must necessarily be removed as part of the procedure. It does not authorise the removal of any additional tissue from the person's body. For this to occur lawfully, the person must specifically consent to the removal of that tissue under different provisions of the Human Tissue Act 1983.

The patient should be given a brief description of the sort of uses to which their tissue may be put (scientific and medical research, teaching, study etc). The patient must also be informed that their consent to the use of tissue is separate from their consent to treatment, and their treatment is in no way affected by a decision not to consent to use of tissue. The optional use of removed tissue section of the consent form should be completed by the patient after discussion with the AMO or a delegate of the AMO.

If the patient does not consent to their tissue being used for other medical, therapeutic or scientific purposes, it should be disposed of in accordance with usual waste management procedures, or in accordance with the patient's wishes if possible.

34. Consent for procedures that a medical practitioner does not "recommend"

The consent forms attached to this Circular require the medical practitioner to sign a section which states s/he has informed the patient about the nature, results and risks of the "recommended procedure". The patient also signs an acknowledgement which states that the medical practitioner has recommended the treatment.

NSW Health's policy is that public health organisations use these consent forms.

However, it is recognised that some procedures, such as terminations of pregnancy and elective circumcisions, are performed which may not be "recommended" by a medical practitioner, or which a medical practitioner may feel uncomfortable about recommending.

PHOs may adopt the following alternative wording on consent forms used for these types of procedures (changes in bold type):

I, Drinsert name of medical practitionerhave **discussed** the following:

.....
INSERT NAME OF PROCEDURE OR TREATMENT. DO NOT USE ABBREVIATIONS

I have informed this **patient** of the matters as detailed below including the nature, likely results, and material risks of the **above** procedure or treatment.

...../...../20.....
 SIGNATURE OF MEDICAL PRACTITIONER. DATE TIME

Interpreter present */...../20.....
 SIGNATURE OF INTERPRETER DATE TIME

Drand I have discussed my present condition and the
 INSERT NAME OF MEDICAL PRACTITIONER
 various ways in which it might be treated. **I have requested** the above procedure or treatment:

35. Research or experimentation?

The approval of the hospital institutional ethics committee must be sought for specific consent protocols for all operations, procedures and treatments involving experimentation. Patient consent should also be obtained in writing.

Special arrangements apply where a person is sixteen years of age or above and is unable to consent. (See Attachment A).

36. Procedures that may affect persons other than the patient

Some procedures, such as HIV testing and genetic testing, may have implications for persons other than the patient undergoing the test or procedure.

In these situations, it is advisable to discuss the possible test results with the patient, and ascertain whether the patient intends to inform identifiable potentially affected third parties of the results. It may even be possible to obtain the patient’s written consent to disclose results to an identifiable third party at this stage.

GUARDIANSHIP ACT 1987 - SUBSTITUTE CONSENT

This attachment sets out the circumstances in which substitute consent can be obtained, from whom and the legal requirements for ensuring that substitute consent is valid.

1. *What is the purpose of the Guardianship Act 1987?*

The Guardianship Act 1987 establishes who can give valid substitute consent in circumstances where a person is unable to consent to medical or dental treatment. The object of the Act is to ensure that:

- people are not deprived of necessary treatment merely because they lack the capacity to consent to the carrying out of such treatment; and
- any treatment that is carried out for such people is carried out to promote their health and well being.

The Act therefore identifies a substitute decision maker for patients unable to consent which is consistent with the level of treatment proposed. In some cases (outlined below) treatment may proceed without consent.

2. *When do the provisions of the Guardianship Act apply?*

The Act applies to a patient who is of or above the age of sixteen years and who is incapable of giving consent to the carrying out of medical or dental treatment. Section 33(2) of the Guardianship Act provides that a person is incapable of giving consent if the person is incapable of understanding the general nature and effect of the proposed treatment, or is incapable of indicating whether or not he or she consents or does not consent to the treatment.

3. *What if the treatment is required in an emergency?*

The Guardianship Act provides that treatment may be provided to a person who is unable to consent where the medical practitioner or dentist carrying out or supervising the treatment considers treatment is necessary as a matter of urgency to save life, to prevent serious damage to patient's health, or (except in the case of ***special medical treatment***), to alleviate significant pain or distress. A substitute consent is not required in these circumstances.

4. *Is medical or dental treatment defined in the Guardianship Act?*

Medical or dental treatment is defined to mean:

- medical treatment (including any medical or surgical procedure, operation or examination and any prophylactic, palliative or rehabilitative care) normally carried out by or under the supervision of a medical practitioner; or
- dental treatment (including any dental procedure operation or examination) normally carried out by or under the supervision of a dentist.

In the case of a clinical trial, medical treatment is taken to include the giving of placebos to some participants in the trial.

However, the Act specifies that this does not include:

- (i) any non intrusive examination made for diagnostic purposes (including a visual

examination of the mouth, throat, nasal cavity, eyes or ears);

- (ii) first aid medical or dental treatment; or
- (iii) the administration of a pharmaceutical drug for the purpose, and in accordance with the dosage level, recommended in the manufacturer's instructions for which a prescription is not normally required and which is normally self administered.

These minor procedures may proceed without consent.

5. *What must a medical practitioner do before they carry out treatment when a person is unable to consent?*

Practitioners should be aware, it is an offence under section 35 of the Act to provide medical or dental treatment to a person who is 16 years or older who is incapable of giving consent unless:

- a substitute consent for the treatment has been obtained in accordance with the Guardianship Act 1987 NSW; or
- the carrying out of the treatment is authorised by the Guardianship Act and no consent is required.

Therefore practitioners need to determine whether treatment can proceed without consent or whether a substitute consent is required, and from whom.

The Act makes different arrangements for obtaining consent depending on the level of intervention proposed. Distinctions are drawn between ***minor treatment***, ***major treatment*** and ***special medical treatment***.

It is the legal responsibility of the medical practitioner carrying out the treatment to ensure that consent has been obtained.

6. *What is special medical treatment?*

Special medical treatment is defined as:

- (a) any treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out;
- (b) any new treatment that has not yet gained the support of a substantial number of medical practitioners or dentists specialising in the area of practice concerned; or
- (c) any treatment declared by the regulations to be special treatment for the purposes of the Guardianship Act

The following treatments have been declared by the Regulations to be special treatment:

- (a) any treatment that involves the administration of a drug of addiction (other than in association with the treatment of cancer or palliative care of a terminally ill patient) over a period or periods totaling more than 10 days in any 30 days;
- (b) any treatment that is carried out for the purpose of terminating pregnancy;
- (c) any treatment in the nature of a vasectomy or tubal occlusion;
- (d) any treatment that involves the use of an aversive stimulus, whether mechanical, chemical physical or otherwise.

Special medical treatment does not include treatment administered in the course of a clinical

trial. Special arrangements apply to such treatment - see paragraph 11.

7. *Who provides substitute consent to special medical treatment?*

Consent to the initial administration of special medical treatment may only be granted by the Guardianship Tribunal. The process for making an application to the Tribunal is detailed later in the document.

Once the initial consent of the Guardianship Tribunal has been obtained, the guardian of a person may consent to the carrying out of continuing or further special treatment if the Tribunal has authorised the guardian to give consent to the continuation of treatment or to further treatment of a similar nature.

Practitioners should note that the Guardianship Regulations identify two specific types of special medical treatment for which different criteria apply for obtaining consent from the Tribunal. These include: (i) any special treatment that involves the administration to a patient of one or more restricted substances for the purpose of affecting the central nervous system of the patient, but only of the dosage levels, combination of the numbers of restricted substances used or the duration of the treatment are outside the accepted mode of treatment; and (ii) any special treatment that involves the use of androgen reducing medication for the purpose of behavioral control. If these treatments are to be administered, the matters should be discussed with the Tribunal.

8. *What is major medical treatment?*

The definition of major medical treatment is broad. It includes:

- (I) any treatment that involves the administration of a long acting injectable hormonal substance for the purpose of contraception or menstrual regulation;
- (ii) any treatment that involves administration of a drug of addiction (except where classified as special medical treatment as outlined above);
- (iii) Any treatment that involves the administration of a general anesthetic or other sedation, but not involving treatment involving:
 - (a) sedation used to facilitate the management of fractured or dislocated limbs; or
 - (b) sedation used to facilitate the insertion of an endoscope into a patient's body for diagnostic purposes unless the endoscope is inserted through a breach or incision in the skin or a mucous membrane.
- (iv) Any treatment used for the purpose of eliminating menstruation;
- (v) Any treatment that involves the administration of a restricted substance for the purpose of affecting the central nervous system, but not a treatment;
 - (a) substance that is intended to be used for analgesic, antipyretic, antiParkinsonian, anticonvulsant, antiemetic, anti-nauseant or antihistaminic purposes; or
 - (b) that is to be given only once; or
 - (c) that is a PRN treatment (that is, given when required, according to the patients needs that may be given not more than 3 times a month); or
 - (d) given for sedation in minor medical procedures.
- (vi) Any treatment that involves a substantial risk to the patient (that is risk that amounts to more than a mere possibility) of: (a) death; or (b) brain damage; or (c) paralysis; or (d) permanent loss of function of any organ or limb; or (e) permanent and disfiguring scarring; or (f) exacerbation of the conditions being treated; or (g) an unusually prolonged period of recovery; or (h) a detrimental change of personality; or (i) a high level of pain and stress.

(vii) Any treatment involving testing for the HIV virus.

Major dental treatment is defined to include treatments involving the administration of a general anesthetic or simple sedation, a procedure intended or likely to result in removal of all teeth, a treatment likely to result in the patients ability to chew food being significantly impaired for an indefinite or prolonged period.

Major treatment does not include treatment administered in the course of a clinical trial

9. What is minor treatment?

Minor treatment is any medical or dental treatment which does not fall within the meaning of special medical treatment or major treatment. As noted at point 4, this does not include a number of specific minor procedures for which no consent is required.

Minor treatment does not include treatment administered in the course of a clinical trial.

10. How is consent obtained for major and minor medical treatment?

Consent to carry out major and minor medical treatment can be obtained from the *person responsible* for the patient within the meaning of the Act. A consent given by a person responsible has effect as if the treatment had been consented to by the patient. However, the consent of a person responsible is not valid if the practitioner carrying out or supervising the treatment is aware or ought to be aware the patient objects to the procedure or treatment or if the proposed treatment is to be carried out for any purpose other than that of promoting or maintaining the health and well-being of the patient.

An objection by the patient may be disregarded if

- (a) the patient has minimal or no understanding of what the treatment entails, and
- (b) the treatment will cause the patient no distress or, if it will cause the patient some distress, the distress is likely to be reasonably tolerable and only transitory.

If the patient objects to the treatment and the objection cannot be disregarded, , the request for consent must be referred to the Tribunal except where a legal guardian of the patient has been specifically authorised by the Tribunal to override the patient's objection. This applies whether the proposed treatment is major or minor.

In the case of major medical treatment the Guardianship Tribunal may also consent to treatment. However, in all instances, practitioners should first ascertain if there is a person responsible for a patient unable to consent before seeking the consent of the Guardianship Tribunal.

Whilst the Guardianship Tribunal can also provide consent to minor treatment, such treatment may be carried out on a patient without consent if there is no person responsible for the patient or the person responsible is unavailable or unwilling to make a decision concerning the patient. In such cases, the practitioner carrying out the minor treatment is required to certify in writing in the patient's clinical record that the treatment is necessary and is the form of treatment that will most successfully promote the patients health and well being; and the patient does not object to the carrying out of the treatment.

If consent is refused by a person responsible and the practitioner remains of the view that the treatment is in the best interests of the patient, the matter should be referred to the Guardianship Tribunal.

11. Treatment administered in the course of a clinical trial

A clinical trial is defined as a trial of drugs or techniques that necessarily involves the carrying

out of medical or dental treatment on the participants in a trial. This includes the administration of placebos to patients.

A person unable to consent may not participate in a clinical trial unless the trial has been approved by the Guardianship Tribunal under the Act. In approving such a trial, the Guardianship Tribunal will decide whether consent can be granted by person responsible or should be granted by the Tribunal.

12. Who is the person responsible for a patient?

The Act establishes a hierarchy for determining who is the person responsible for a person unable to consent to treatment.

- If the person is under guardianship, the guardian is the person responsible.
- If there is no guardian, an enduring guardian appointed by the patient with authority to make decisions regarding medical care (see section 13 of this Attachment)
- If there is no enduring guardian, a spouse (including a de facto spouse) with whom the person has a close continuing relationship is the person responsible.
- If there is no guardian or spouse, a person who has the care of the patient unable to consent is the person responsible. Such a person is regarded to have the care of the patient if they have provided, or have arranged to be provided, domestic services and support otherwise than for remuneration. Where the patient has been cared for by a person in a nursing home, hostel, boarding house or other group accommodation, that person does not have care of the person. In such cases the patient remains in the care of the person he or she was immediately with before residing in the institution.
- If there is no guardian, spouse, or carer, a close relative or friend may act as the person responsible provided they are not receiving remuneration for any services provided.

If the person is in the care of the Director-General under s 13 of the Guardianship Act, the Director-General of the Department of Community Services is the person responsible.

13. Who is an enduring guardian?

Until 1997, guardians were appointed by either the Tribunal or the Supreme Court. However, amendments to the Act provided that an individual may appoint an enduring guardian to carry out certain roles and functions where the individual lacks sufficient capacity to make appropriate decisions.

A person 18 years of age or above may appoint an enduring guardian. Such an appointment must be made on the prescribed form, copies of which are available from the Guardianship Tribunal, and be witnessed by a legal practitioner or a clerk of the local court.

An appointment only has effect during a period in which the person is in need of a guardian. Further, the decisions which an enduring guardian may make on behalf of the person in need of a guardian are determined by the prescribed form appointing the person. As the person appointing the enduring guardian may limit the decisions which may be made by the appointee, practitioners should ask to review the appointment form to ensure that the enduring guardian has power to make decisions in relation to medical or dental treatment.

14. Guardians appointed under interstate or NZ legislation

A person who has been appointed as a guardian of another person and is able to consent to medical treatment on behalf of that person pursuant to the guardianship legislation of another State or Territory or the Protection of Personal and Property Rights Act 1988 of New Zealand, may apply to the NSW Guardianship Tribunal for recognition of their status as such in NSW. If the NSW Guardianship Tribunal recognises the interstate or NZ guardian as such, that person is

to be taken as having been appointed as a guardian under the NSW Guardianship Act.

15. What is required to obtain consent from a person responsible?

A request to a person responsible for consent may be made by any person. Such a request shall specify the following information:

- (a) the grounds on which it is alleged that the patient is a patient to whom this part applies;
- (b) the particular condition of the patient that requires treatment;
- (c) the alternative courses of treatment that are available in relation to that condition;
- (d) the general nature and effect of each of the courses of treatment;
- (e) the nature and degree of the significant risks (if any) associated with each of these courses of treatment; and
- (f) the reasons for which it is proposed that any particular course of treatment should be carried out.

A request to a person responsible is to be made in writing. However:

- (i) if the request is for major medical treatment, it may be made orally if it is not practicable to make the request in writing because of the need to provide the treatment quickly.
- (ii) if the request is for minor medical or dental treatment, the request may be made orally, if it is not practicable to make the consent in writing or the person whose consent is sought does not require the consent to be made in writing.

Written confirmation of an oral request for consent must be provided for major treatment or for minor treatment where the person whose consent was sought requires confirmation.

16. What must the person responsible do to grant a valid consent?

In all cases, the person responsible must consider the views (if any) of the patient, the information provided by the person requesting consent and the objectives of the Act. Consent to the carrying out of major medical treatment is to be given in writing, however, the consent may be given orally if it is not practicable to do so in writing because of the need to provide treatment quickly. Written confirmation of the consent must be provided where oral consent is provided.

Consent to the carrying out of minor medical treatment is also to be given in writing, although it may be given orally if: (i) it is not practical to give written consent; and (ii) the person by whom the treatment is to be carried out does not require it to be given in writing. However, written confirmation of the consent may be requested.

17. Do records need to be kept?

A person who carries out treatment pursuant to a substitute consent is to keep a written record of the name of the person by whom consent was given, the date, conditions on the consent and the treatment. If written consent was obtained, the form should be kept. Such records must be retained for seven years.

18. The Public Guardian

Guardianship Tribunal may appoint the Public Guardian as a person's guardian with the

functions of providing consent to medical or dental treatment. If the patient's guardian is the Public Guardian, you should contact the Office of the Public Guardian to seek consent for the proposed treatment from the officer responsible for the patient's guardianship decisions. The Office of the Public Guardian has an application form for this purpose. It is entitled "Application to carry out medical or dental treatment for a person under the guardianship of the Public Guardian."

19. *What if an application needs to be made to the Guardianship Tribunal?*

Requests to the Guardianship Tribunal for consent generally require the same information that needs to be provided to a person responsible. A standard request form is available from the Guardianship Tribunal. Further information, including brochures can be found on the Tribunal's website, www.gt.nsw.gov.au.

ATTACHMENT B

USEFUL CONTACTS

Department of Community Services

Street address: 4-6 Cavill Avenue
Ashfiled NSW 2131

Postal Address: Locked Bag 28
Ashfiled NSW 1800

Phone: DoCS Helpline 13 3627 (or 13 DOCS) to make a
report. (24hours)
(02) 9716 2222 (Head Office)

Fax: (02)9716 2999 (Head Office)

Website: <http://www.community.nsw.gov.au>
Follow the links to “protecting children” and “for
mandatory reporters”

Guardianship Tribunal

Street address: Level 3
2a Rowntree Street
Balmain NSW 2041

Postal Address: Locked Bag 9
Balmain NSW 2041

Phone: (02) 9555-8500 or
1800 463 928

Fax: (02) 9555-9049

Website: www.gt.nsw.gov.au
Email: gt@gt.nsw.gov.au

Mental Health Review Tribunal

Street address: Building 40 Digby Road
Gladesville Hospital
Gladesville NSW 2111

Postal Address: PO Box 2019
Boronia Park
NSW 2111

Phone: (02) 9816 5955
1800 815 511

Fax: (02) 9817 4543

Website: <http://www.mhrt.nsw.gov.au>

Email: mhrt@mhrt.nsw.gov.au

NSW Health Legal Branch

Street address: 73 Miller Street
North Sydney NSW 2060

Postal Address: Locked Mail Bag 961
North Sydney NSW 2059

Phone: (02) 9391 9606

Fax: (02) 9391 9604

Legal Branch Website: <http://internal.health.nsw.gov.au/csd/lisb/>
(intranet)

To access copies of NSW Health Circulars: <http://internal.health.nsw.gov.au/policies/>
(intranet)

Email: legal@doh.health.nsw.gov.au

The Public Guardian

Street address: Level 15, Piccadilly Tower
133 Castlereagh St
SYDNEY NSW 2000

Postal Address: PO Box A231
SYDNEY SOUTH NSW 1235

Phone: (02) 9265 3184
1800 451 510

Fax: 02 9283 2645

Website: www.lawlink.nsw.gov.au/opg

If you need to contact the Public Guardian for an *urgent* decision outside of office hours, call 02 9265 3184 and you will hear a recorded message which will give you the number for a pager service. Give the pager service your name and number and a staff member from the Office of the Public Guardian will return your call. Do not give any information regarding the client to the paging service.

(NAME OF HOSPITAL)

**REQUEST/CONSENT FOR
MEDICAL PROCEDURE
TREATMENT**

TITLE	FAMILY NAME	MRN		
GIVEN NAMES		VMO		
ADDRESS	STREET	DOB	SEX	HIS
SUBURB	POSTCODE	ADMISSION DATE		

(For patients 14 years and above - not for Guardianship Act purposes)

PROVISION OF INFORMATION TO PATIENT

To be completed by Medical Practitioner

I, Drinsert name of medical practitionerhave discussed with this patient the various ways of treating the patient's present condition including the following proposed procedure/treatment.....

..... INSERT NAME, SITE AND REASONS FOR PROCEDURE OR TREATMENT. DO NOT USE ABBREVIATIONS

I have informed this **patient** of the matters as detailed below including the nature, likely results, and material risks of the proposed procedure or treatment.

...../...../20.....
SIGNATURE OF MEDICAL PRACTITIONER. DATE TIME

Interpreter present */...../20.....
SIGNATURE OF INTERPRETER DATE TIME

PATIENT CONSENT

To be completed by Patient

Drand I have discussed my present condition and the various ways in which it might be treated, including the above procedure or treatment:

The doctor has told me that:

- the procedure/treatment carries some risks and that complications may occur;
- an anaesthetic, medicines, or blood transfusion may be needed, and these may have some risks;
- additional procedures or treatments may be needed if the doctor finds something unexpected;
- the procedure/treatment may not give the expected result even though the procedure/treatment is carried out with due professional care.

I understand the nature of the procedure and that undergoing the procedure/treatment carries risks.

I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

I understand that I may withdraw my consent.

**I have been told that another doctor may perform the procedure/treatment.*

I **request and consent** to the procedure/treatment described above for me.

(NAME OF HOSPITAL)

REQUEST/CONSENT FOR MEDICAL PROCEDURE TREATMENT

Table with patient information: TITLE, FAMILY NAME, MRN, GIVEN NAMES, VMO, ADDRESS, STREET, DOB, SEX, HIS, SUBURB, POSTCODE, ADMISSION DATE.

(For parents/guardians of patients less than 16 years of age)

PROVISION OF INFORMATION TO PATIENT

To be completed by Medical Practitioner

I, Drinsert name of medical practitioner. have discussed with this patient's parent/guardian the various ways of treating the patient's present condition including the following proposed procedure/treatment:.....

.....INSERT SITE AND NAME AND REASONS FOR PROCEDURE OR TREATMENT. DO NOT USE ABBREVIATIONS

I have informed this parent/guardian* of the matters detailed below including the nature, likely results, and material risks of the proposed procedure or treatment.

...../...../20.... SIGNATURE OF MEDICAL PRACTITIONER. DATE TIME

Interpreter present */...../20.... SIGNATURE OF INTERPRETER. DATE TIME

PATIENT CONSENT

To be completed by Parent/Guardian

Drand I have discussed the present condition of INSERT NAME OF MEDICAL PRACTITIONER INSERT NAME OF MINOR

and the various ways in which it might be treated, including the above procedure or treatment:

The doctor has told me that:

- the procedure/treatment carries some risks and that complications may occur;
an anaesthetic, medicines, or blood transfusion may be needed, and these may have some risks;
additional procedures or treatments may be needed if the doctor finds something unexpected;
the procedure/treatment may not give the expected result even though the procedure/treatment is carried out with due professional care.

I understand the nature of the procedure and that undergoing the procedure/treatment carries risks.

I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

I understand that I may withdraw my consent.

*I have been told that another doctor may perform the procedure/treatment.

I request and consent to the procedure/treatment described above for INSERT NAME OF MINOR

DELETE IF NOT REQUIRED

This part must be countersigned by your doctor

While I consent to the above procedure/treatment, after discussing this matter with the doctor, I refuse consent for my child to have the following aspects of the recommended procedure or treatment.

insert Objection.....Practitioner's Acknowledgement.....

I note that the Children and Young Person's (Care and Protection) Act 1998 provides that such treatment may be provided notwithstanding my objection if it is necessary to prevent death or serious injury to my child.

I also consent to anaesthetics, medicines or other treatments, which could be related to this procedure/treatment.

I **consent/do not consent*** to a blood transfusion if needed.

.....Signature of Parent/Guardian..... /...../20.... .print name of parent/guardian.....

..... ADDRESS.....

.....

USE OF REMOVED TISSUE – (SEE SECTION 33 of CIRCULAR)

I understand that the above procedure may involve the removal of some bodily tissue, which may be required for the diagnosis, or management of’s condition.
INSERT NAME OF MINOR

I **consent/do not consent*** to the use of such tissue for any medical, therapeutic or scientific purpose, in addition to purposes related to the diagnosis or management of’s condition.
INSERT NAME OF MINOR

My consent is conditional on the following terms:

..... (insert terms, if any)

This consent extends only to tissue, which is removed for the purposes of the above procedure.

.....Signature of Parent/Guardian...../.....20.....

*Delete where not applicable

**SUBSTITUTE CONSENT FOR
MEDICAL TREATMENT**

GUARDIANSHIP ACT 1987

(For patients 16 years and above where consent is provided by a person responsible)

TITLE	FAMILY NAME	MRN		
GIVEN NAME/S		VMO		
ADDRESS	STREET	DOB	SEX	HIS
SUBURB		POSTCODE	ADMISSION DATE	

Medical Advice To be completed by Medical Practitioner

I, Dr confirm that is
INSERT NAME OF MEDICAL PRACTITIONER INSERT NAME OF PATIENT

incapable of consenting to medical treatment because:

- (Tick one) he/she cannot understand the nature and effect of the treatment
 or
 he/she cannot indicate whether or not he/she consents

The patient's condition that requires treatment is

Significant risks in not treating are

The site of the proposed procedure or treatment and its general nature and effect are

DO NOT USE ABBREVIATIONS

The proposed procedure/treatment has the following significant risks and/or side effects

Reasonable alternatives (if any) to the proposed procedure/treatment and significant risks and/or side effects associated are

The proposed treatment is the most appropriate form of treatment to promote the patient's health and well-being.

.....and I have discussed the patient's present condition and
NAME OF PERSON RESPONSIBLE

I have also explained:

- that other forms of treatment, such as anaesthetics, medicines, or blood transfusions, may be associated with the procedure/treatment and that these may carry some risks;
- that other unexpected procedures or treatments are sometimes necessary;
- that complications may occur or the expected result may not be achieved even though the procedure/treatment is carried out with due professional care.

...../...../20.....
SIGNATURE OF PERSON RESPONSIBLE DATE SIGNATURE OF MEDICAL PRACTITIONER DATE

Interpreter present */...../20.....
SIGNATURE OF INTERPRETER DATE

REQUEST/CONSENT FORM - SUBSTITUTE CONSENT

Acknowledgement of advice

To be completed by the person responsible/guardian

Dr and I have discussed
INSERT NAME OF MEDICAL PRACTITIONER INSERT NAME OF PATIENT

present condition and the various ways in which it might be treated as above. The doctor has told me that:

- The procedure/treatment carries some risks and that complications may occur;
- The patient may need an anaesthetic, medicines or blood transfusion, and these may have some risks;
- Additional procedures or treatments may be needed if the doctor finds something unexpected;
- The procedure/treatment may not give the expected result even though the procedure/treatment is carried out with due professional care.

I understand the nature of the procedure and that undergoing the procedure/treatment carries risk.

I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

...../...../20.....
SIGNATURE OF PERSON RESPONSIBLE OR GUARDIAN DATE PRINT NAME OF PERSON RESPONSIBLE OR GUARDIAN

Substitute consent

To be completed by the person responsible/guardian

I consent to the procedure/treatment described above for
INSERT NAME OF PATIENT

DELETE IF NOT REQUIRED This part must be countersigned by the doctor if retained

Except that after discussing this matter with the doctor, I do not agree to the patient having the following aspects of the recommended procedure or treatment.

INSERT OBJECTION

PRACTITIONER'S ACKNOWLEDGEMENT

I have considered the views of and consider the treatment should
INSERT NAME OF PATIENT
be provided to the patient. I am satisfied the treatment will promote the health and wellbeing of the patient.

I accept the risks involved in the procedure/treatment.

I also consent to anaesthetics, medicines or other treatments which could be related to this procedure/treatment.

I consent/do not consent* to a blood transfusion if needed.

...../...../20.....
SIGNATURE OF PERSON RESPONSIBLE OR GUARDIAN DATE PRINT NAME OF PERSON RESPONSIBLE OR GUARDIAN

RELATIONSHIP TO PATIENT IN TERMS OF THE ACT

ADDRESS

Use of removed tissue – (See Section 33 of Circular)

I understand that the above procedure may involve the removal of some bodily tissue, which may be required for the diagnosis, or management of
INSERT NAME OF PATIENT's condition.

I consent/do not consent* to the use of such tissue for any medical, therapeutic or scientific purpose, in addition to purposes related to the diagnosis or management of
INSERT NAME OF PATIENT's condition.

My consent is conditional on the following terms:

(INSERT TERMS, IF ANY)

This consent extends only to tissue, which is removed for the purposes of the above procedure.

...../...../20.....
SIGNATURE OF PERSON RESPONSIBLE OR GUARDIAN DATE

*Delete where not applicable

REQUEST/CONSENT FORM - SUBSTITUTE CONSENT