

NSW Health

Consent to Medical and Healthcare
Treatment Manual



NSW Ministry of Health
100 Christie Street
ST LEONARDS NSW 2065
Tel. (02) 9391 9000
Fax. (02) 9391 9101
TTY. (02) 9391 9900
www.health.nsw.gov.au

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The NSW Ministry for Health acknowledges the traditional custodians of the lands across NSW. We acknowledge that we live and work on Aboriginal lands. We pay our respects to Elders past and present and to all Aboriginal people.

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1. Definitions and interpretation

Certain capitalised words used in this Consent Manual have defined meanings. Where the term is used in one section only, it is usually defined in that section. Otherwise, the capitalised words have the meaning defined below. Some words defined below are used throughout the document but not capitalised.

Term	Meaning
Admitting Medical Officer	The Visiting Medical Officer, Staff Specialist, Honorary Medical Officer or Clinical Academic under whom the patient has been admitted and who is responsible for the clinical care of the patient for the particular episode of care.
Advance Care Directive (ACD)	A legally binding direction made by a patient with capacity, which describes a patient's future preference for the medical treatment they do or do not wish to have in the future, that will apply when the patient loses capacity.
Advance Care Planning	A discussion about a patient's values and the type of health care they would want to receive in the event they become seriously ill or injured and are unable to say what they want. Advance Care Planning does not necessarily result in a legally binding Advance Care Directive, but can do so.
Capacity	The ability of a patient to consent or refuse medical treatment. Capacity is used in this document rather than the term competent.
Gillick Competent	See Mature Minor . The <i>Gillick</i> case held that a child's capacity to consent increases as they approach maturity, or, in other words, the authority of a parent decreases as their child's capacity increases.
Health Literacy	How well individuals can access, understand and apply health information, so that they can make good decisions about their health.
Health Practitioner	An individual who practises a health profession (e.g. Medical Practitioners, Nurses, Midwives, Dentists) and who is registered under the <i>Health Practitioner Regulation National Law</i> . A Health Practitioner also includes staff that provide a health service but that are not required to be registered under the National Law, for example, speech pathologists and dieticians. A Health Practitioner is authorised by a public health organisation or NSW Ambulance to provide medical and healthcare treatment to a patient.
Health Record	A documented account, whether in hard or electronic form, of a patient's health, illness and treatment during each visit or stay at a Health Service or an episode of care. Health Record in this document has the same meaning as health care record, medical record, clinical record, clinical notes, patient records and so on.
Health Service	A Local Health District, Specialty Network, Affiliated Health Organisation or unit of the Health Administration Corporation that provides health services (for example the NSW Ambulance or NSW Health Pathology) as part of the NSW public health system.
Junior Medical Officer	A registrar (including basic and advanced trainees), junior medical officers and interns PGY1.
Mature Minor	A Minor who has a sufficient level of understanding and intelligence to enable them to understand fully what medical or healthcare treatment is proposed. Mature Minors may independently consent to or refuse medical or healthcare treatment. There is no set age at which a child or young person is capable of giving consent. It depends upon the treatment being proposed and the minor's ability to fully understand the implications of that treatment. The term Mature Minor is interchangeable with the term <i>Gillick</i> Competent. A court may still override a Mature Minor's consent to or refusal of treatment in the Mature Minor's best interests.
Medical Practitioner	A person registered to practise as a Medical Practitioner under the <i>Health Practitioner Regulation National Law</i> .

Term	Meaning
Minor	A child or young person under the age of 18 years.
must	Indicates a mandatory action that must be complied with.
Nurse or Midwife	A person registered as an enrolled nurse, registered nurse, midwife or endorsed nurse or midwife practitioner under the <i>Health Practitioner Regulation National Law</i> .
Nurse Practitioner	A registered nurse endorsed as a nurse practitioner under the <i>Health Practitioner Regulation National Law</i> . A Nurse Practitioner is educated and endorsed to function autonomously and collaboratively in an expanded and extended clinical role. The Nurse Practitioner role involves comprehensive health assessment, initiation and interpretation of diagnostic investigations, formation of diagnosis, prescribing of medications and other therapeutic intervention and the referral of patients to and from other Health Practitioners.
Patient	Any person who receives a health service and to whom, as a result, a Health Practitioner owes a duty of care. It also includes consumers, clients and the relevant substitute decision maker where the patient does not have capacity to consent.
Person Responsible	A person entitled to provide consent to medical treatment on behalf of another person over 16 years of age who lacks capacity, under the hierarchy set out in the <i>Guardianship Act 1987</i> . This may include an enduring guardian, if one has been appointed. The term next of kin is not used in this document. A nominated next of kin may not be the Person Responsible and may have no legal authority to provide consent to medical or healthcare treatment on behalf of a patient without capacity.
should	Indicates a recommended action that should be followed unless there are sound reasons for taking a different course of action.
Special Medical Treatment	Type of medical treatment requiring additional consent or approval pursuant to legislation. Also known as Special Treatment.

2. Executive Summary

2.1. Overview

This is the first edition of the NSW Health *Consent to Medical and Healthcare Treatment Manual (Consent Manual)* and replaces the NSW Health Policy Directive *Consent to Medical Treatment, Patient Information PD2005_406*.

The Consent Manual provides operational guidance and procedures to support compliance with the NSW law on obtaining consent to medical treatment from patients or their substitute consent providers.

The Consent Manual incorporates changes in legislation and NSW Health policy which impact on the legal obligations for obtaining consent to medical treatment, including:

- changes to the *Mental Health Act 2007*, including the removal of the concept of 'Primary Carers' and the introduction of 'Designated Carers' and 'Principal Care Providers'
- changes to the *Health Records and Information Privacy Act 2002* (NSW) regarding the disclosure of genetic information to affected relatives
- clarification that Mature Minors can consent to or refuse their own treatment, and the circumstances where these decisions can be overridden
- guidance for Health Practitioners when patients refuse recommended medical treatment in an obstetric setting
- guidance for Health Practitioners when patients or their parents/guardians seek discharge against medical advice.

Consultation on the Consent Manual has extended to:

- Local Health Districts, Specialty Networks and other health organisations comprising NSW Health
- other relevant agencies including Department of Communities and Justice and the NSW Civil and Administrative Tribunal
- other relevant stakeholders including medical defence organisations, health professional registration bodies and Colleges
- consumer organisations.

The Consent Manual has been developed to achieve the following outcomes:

- assist Health Practitioners and managers in understanding the legal requirements for providing appropriate and adequate information to patients, including material risks of specific treatments, procedures and obtaining valid patient consent for such treatment / procedures to help them in discharging their legal obligations
- alert Health Practitioners and managers to their legal obligations with regard to providing treatment to patients who do not have capacity to consent.
- patient consent or refusal of treatment is recorded and documented appropriately
- patient autonomy and decision making is respected and patients are provided with appropriate information relevant to their treatment.

The Consent Manual contains a number of example scenarios, based on real incidents, in the blue boxes. The Consent Tables - Quick Finders in section 11 of this Consent Manual provide a useful for a summary of the relevant consent requirements.

2.2. Principles informing this policy

The Consent Manual has been formulated using the following fundamental principles:

- Adults with capacity have a right to decide what happens to their own bodies. This means that, in general, treatment cannot be provided without consent
- Adults with capacity have the right to refuse treatment, for any reason, even if refusal of treatment is likely to lead to serious injury or death
- Health Practitioners should assume that adult patients have capacity to consent unless there is evidence to contradict this assumption
- Patients (including adults, young people and children) must be provided with enough information about their condition, treatment options and prognosis in order to enable them to make or contribute to decision relating to their health care and promote supported decision making
- Information provided to patients needs to be tailored to the individual's needs and circumstances, including that individual's Health Literacy level
- Consent processes promote patient centred care that is respectful of, and responsive to, individual patients' preferences, needs and values and ensures that the patient's values guide all clinical decisions
- Consent processes promote cultural responsiveness in health services thereby improving the capacity to respond to the healthcare needs of culturally and linguistically diverse communities.
- Subject to accepted legal and ethical standards of medical care, patients without the capacity to consent have a right to a substitute decision maker and to be provided with care consistent with any valid ACD that they have made.

2.3. Quick reference guide to the structure of the Consent Manual

Aspect of Consent	Go to section
Why it is necessary to obtain consent and warn patients about material risks	Section 4.1
What are the requirements for obtaining a valid consent	Section 4.3
Emergency treatment	Section 4.2.1
How do I properly inform a patient about a procedure and warn of material risks?	Section 4.8
Who should obtain consent?	Section 5
Can a patient refuse treatment?	Section 6.1
Refusal of treatment using an Advance Care Directive	Section 6.2
Patients (16 years or over who do not have capacity to consent)	Section 7
Consent to medical treatment for Minors including non-emergency treatment and sexual health treatment	Section 8
Requirements for consent Treatment lawfully authorised or required	Section 4 Section 4.2.2
Useful Contacts	Section 12
Consent for patients being treated under the <i>Mental Health Act 2007</i>	Section 9
Types of treatment under the Guardianship Act and consent requirements	Section 7.7
What are the legal requirements for Special Medical Treatment in relation to children?	Section 8.11
NSW Health State Forms relating to consent	Section 3.6

If you have any feedback on the Consent Manual, it should be sent to:

Legal and Regulatory Services
 NSW Ministry of Health
 Locked Mail Bag 961 North Sydney NSW 2059
 Email: NSWH-LegalMail@health.nsw.gov.au

3. Scope

3.1. Who is bound by the Consent Manual?

The Consent Manual is mandatory for all people who work within the NSW public health system. This includes, but is not limited to, staff members, contractors, and other health care providers who, in the course of their work, are involved in providing a health service or treatment to patients of NSW Health Services.

Health Practitioners must also comply with relevant professional practice standards and legislation.

3.2. Roles and responsibilities of Health Services

Chief Executives of Health Services must ensure that:

- the principles and requirements of this Consent Manual are applied, achieved and sustained
- staff are made aware of their obligations in relation to obtaining consent
- documented procedures are in place to support the implementation of the Consent Manual
- documented procedures are in place to effectively respond to and investigate any breaches of the Consent Manual.

Facility managers and Health Practitioners have a responsibility to ensure that the principles of this Consent Manual are applied and achieved. They are to understand:

- the legal requirements for obtaining consent
- what information must be provided to a patient before a patient gives their consent
- when consent should be provided by a substitute decision maker, how to correctly identify who the substitute decision maker is and how to seek substitute consent
- the requirement to document consent and the consent process.

3.3. What does the Consent Manual cover?

The Consent Manual explains the law and provides practical guidance for Health Practitioners about obtaining consent from patients of NSW Health Services for medical treatment and other healthcare. It covers the legal requirements for obtaining valid patient consent including with respect to those patients who do not have the capacity to consent to treatment for themselves. The Consent Manual also provides specific guidance on obtaining consent to some particular procedures/treatment, for example, blood transfusions and obstetric procedures.

3.4. What is not covered?

The Consent Manual does not cover consent relating to areas such as:

- consent to financial expenses relating to medical treatment
- consent related to the use, disclosure or storage of health information, including consent for photographing or filming treatment for training or research purposes, (see *Privacy Manual for Health Information*)
- consent to the removal and use of human tissue (including organ donation) (see *Deceased Organ and Tissue Donation – Consent and Other Procedural Requirements* (PD2013_001) and *Donation, Use and Retention of Tissue from Living Persons* (PD2016_001))
- consent to non-coronial post mortems (see *Non-Coronial Post Mortems* (PD2013_051))

- consent to participate in the NSW Health Statewide Biobank (see <https://biobank.health.nsw.gov.au/biobanking-framework/nsw-health-biobank-consent-toolkit/>)
- consent to compulsory forensic blood and alcohol testing in Emergency Departments.
- consent to Aged Care Assessments (see *My Aged Care Assessment Manual*).

3.5. What other NSW Health resources should be considered?

There are a range of NSW Health policies which are relevant to obtaining the consent of patients to medical treatment in Health Services. While the main policies are referenced in the body of the Consent Manual, see also the list of related NSW Health policies and legislation in Appendix 1.

3.6. NSW Health State Forms relating to consent

This Consent Manual attaches the key State Forms for recording patient consent to medical procedures/treatment:

- Consent for Medical Procedure/Treatment (Adult and Mature Minors) – for patients with capacity
- Consent for Medical Procedure/Treatment (Minors) – for parents/guardians of minors without capacity
- Consent – Substitute Consent for Medical Procedure/Treatment – *Guardianship Act 1987*
- Procedure/Treatment Refusal Acknowledgement (Patient with Capacity)
- Discharge against Medical Advice (Adult with Capacity)
- Discharge against Medical Advice (Parents/Guardians of Minors)

The following additional State Forms document consent for related purposes and can be obtained from the State Forms Committee or within the relevant policy document:

- Consent for oral health treatment
- Consent for the NSW Rheumatic Heart Disease Register
- Consent for genetic testing (PD2007_066, PD2005_303, GL2007_013)
- Forms relating to mental health assessments
- Forms for consents relating to human tissue/organ donation
- BreastScreen consent forms
- Photo and Video Imaging in Cases of Suspected Child Sexual Abuse, Physical Abuse and Neglect (PD2015_047)
- Consents for public health screening:
 - Statewide Infant Screening – Hearing (GL2010_002)
 - Various immunisation policies
 - Statewide Eyesight Preschooler (StEPS) Screening flyer
- RhD Immunoglobulin Patient Consent (GL2015_011)
- *Sexual Assault Medical Forensic Examination Consent* form (refer to section 10.8) (PD2005_607)
- Sexual Assault Medical Forensic Examination Record (MFER) and the Suspected Child Abuse and Neglect (SCAN) Medical Protocol (GL2014_012)
- Forms under the *Mental Health Act 2007*.

4. Requirements for consent

4.1. Why is it necessary to obtain patient consent and warn patients about material risks?

Adults with capacity have a right to decide what happens to their own bodies. This means that they have the right to consent to treatment, refuse to consent to treatment for any reason, or withdraw their consent, even if refusal or withdrawal of treatment is likely to lead to serious injury or death. These principles are reflected in the law that governs consent to medical treatment. As a general rule, no operation, procedure or treatment may be undertaken without prior consent from the patient or, if the patient lacks capacity, from the patient's substituted decision maker.

The only exceptions are:

- in an emergency when the patient lacks capacity and the patient's express wishes are unknown; or
- where the law otherwise allows or requires treatment to be given without consent.

Consent to the general nature of a proposed operation, procedure, or treatment must be obtained from the patient or, if the patient lacks capacity, from the patient's substituted decision maker. Failure to do this could result in legal action for assault and battery against the Health Practitioner who provided the care, irrespective of whether the patient suffered harm as a result of the procedure.

Health Practitioners also have a legal obligation to provide patients (or substituted decision makers) with information, including warnings, about any material risks involved in the proposed procedure or treatment. Failure to do so may also give rise to legal action for negligence. For further information on material risks see section 4.8.

Obtaining consent and adequately informing patients about their treatment options and the risks and benefits arising are an established part of good clinical practice.

Further guidance

- Section 4.8 – How do I properly inform a patient about a procedure and warn of material risks?
- NSW Health Policy Directive *Your Health Rights and Responsibilities* (PD2011_022)

4.2. When can treatment be provided without consent?

4.2.1. Emergency treatment

Consent is generally not required where the patient lacks capacity and immediate treatment is necessary to save a person's life or prevent serious injury to their health. Treatment in this context extends to all actions reasonably required to provide the treatment, such as restraint. Treatment (other than Special Medical Treatment) can also be provided without consent to alleviate significant pain and distress. However, treatment cannot be provided without consent in an emergency if providing the treatment would be contrary to a valid prior refusal of treatment, such as an ACD.

This emergency principle also applies to Minors. 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, regardless of capacity, if the treatment is required urgently to save the life or prevent serious damage to the health of the child or young person.

Where treatment is provided without consent in an emergency, this must be documented in the patient's Health Record.

Further guidance

- Section 6.2 – Refusal of treatment using an Advance Care Directive
- Section 8 – Minors

4.2.2. Treatment lawfully authorised or required

Consent of the patient (or their Person Responsible) is not required for treatment which is authorised by legislation or by an order of a court, Tribunal or authorised person.

Orders

Treatment orders can be made by courts or Tribunals. Examples include an order of the NSW Civil and Administrative Tribunal (NCAT) for Special Medical Treatment or an order for treatment under a public health order, or an order of the NSW Supreme Court in exercise of its *parens patriae* jurisdiction.

Statutory requirements

Some procedures authorised by legislation may proceed without consent, for example, compulsory drug and alcohol testing of blood following a road accident.

Legislation may also impose specific processes that must be followed to lawfully provide treatment with or without consent. For example, there are specific methods to obtain consent and forms to record consent:

- for patients receiving electro-convulsive therapy and for surgical treatment provided to involuntary patients under the *Mental Health Act 2007*
- for involuntary treatment for severe substance dependence under the *Drug and Alcohol Treatment Act 2007*
- for treatment provided to inmates in a corrective facility under section 73 of the *Crimes (Administration of Sentences) Act 1999*
- for Special Medical Treatment under the *Guardianship Act 1987*.

In cases where treatment is authorised without consent, it is good clinical practice to engage with the patient and/or their Person Responsible in discussing, documenting and progressing the planned treatment.

Further guidance

- Section 9 - Consent for patients being treated under the *Mental Health Act*
- NSW Health Policy Directive *Blood and Alcohol Sampling by Hospital Staff* (PD2005_495)

4.3. What are the requirements for obtaining a valid consent?

Four core criteria must be met:

- the patient giving consent must have **capacity**
- the consent must be **freely given**
- the consent must be **sufficiently specific** to the procedure or treatment proposed
- the consent must be **informed**.

The four criteria for a valid consent must be met irrespective of whether the consent is in writing or oral. The mere mechanical signing of a consent form is, of itself, of limited value and is not necessarily a evidence of a valid consent.

4.3.1. Capacity

The patient must have the capacity to give consent. A person has decision making capacity if they can:

- understand the facts and choices involved
- weigh up the consequences and
- communicate their decision.

Legally, adults are presumed to have capacity to consent to or refuse medical treatment unless otherwise indicated. Capacity or lack of capacity should not be assumed on the basis of a patient's diagnosis or condition. For example, a patient with an intellectual disability may have capacity to make decisions about their own health treatment if information is provided to them in an appropriate manner or with appropriate assistance. See section 4.8.7 on making 'reasonable adjustments' to support inclusive and accessible services to people with a disability. Essentially, information should be provided in the format that is more

typically used by the client – for example, picture symbols, large print. Patients should be assisted or supported to make their own decisions as far as possible.

Section 33(2) of the *Guardianship Act 1987* provides that a person is incapable of giving consent to the carrying out of medical or dental treatment if the person:

- (a) is incapable of understanding the general nature and effect of the proposed treatment, or
- (b) is incapable of indicating whether or not he or she consents or does not consent to the treatment being carried out.

The NSW Department of Communities and Justice *Capacity Toolkit* also provides some useful, general principles to follow when assessing capacity:

- always presume a person has capacity
- capacity is decision-specific (for example capacity may fluctuate (see below) or certain simple health treatments may be within a person's capacity to consent whilst others may not)
- don't assume a person lacks capacity based on appearances
- assess the person's decision making ability not the decisions they make
- respect a person's privacy
- substitute decision making is a last resort.

A person's capacity may fluctuate from time to time throughout a treatment process as a result of an illness or condition that worsens sporadically such as a mental illness or delirium. The effects of drugs, alcohol or anaesthetics may also render a person temporarily unable to understand the consent process.

An involuntary patient under the *Mental Health Act 2007* does not necessarily lack capacity for making treatment decisions. Health Practitioners will need to consider whether the mental illness suffered by the person is affecting their capacity to consent to the medical treatment at that time.

Minors with sufficient maturity and intelligence to fully understand the procedure or treatment proposed have the capacity to consent (Mature Minors). If a Minor is assessed as *not* having the necessary level of maturity in relation to the treatment being discussed, the consent of a parent or guardian must be obtained.

Where there remains ambiguity or uncertainty about a person's capacity it is advisable to seek expert assessment and advice.

Further guidance

- NSW Department of Communities and Justice *Capacity Toolkit*
- Section 8 – Minors

4.3.2. Freely given

Consent must be freely given. The patient must not be pressured, coerced or intimidated into giving consent by Health Service staff, a Health Practitioner, a carer or a family member. If a Health Practitioner has concerns about whether a patient is being coerced into giving consent, the Health Practitioner should consider asking to speak to the patient alone without the presence of other family members to explore the patient's view.

4.3.3. Sufficiently specific

The consent must be specific and is valid only for the condition being treated and the specified treatment or procedure about which the patient has been informed and agreed to.

Courts have ordered Medical Practitioners to pay compensation to patients where they have undertaken additional procedures outside the original consent, even where the additional procedure appeared clinically appropriate. While this will not prevent treatment required in an emergency, it reinforces the importance of ensuring the patient gives specific consent.

Example

The patient's situation: A surgeon was performing an operation on the colon for colon cancer on a 35-year-old female patient. The patient had capacity and had consented to the procedure. However, during the operation, the surgeon was concerned that the patient's ovaries and fallopian tubes looked abnormal. The surgeon requested the advice of a gynaecologist who attended the operating theatre and advised on the patient's condition during the operation. The gynaecologist considered that the fallopian tubes and ovaries were abnormal, with multiple cysts, and there was endometriosis in the patient's pelvis.

Treatment without specific consent: The surgeon proceeded to remove the patient's ovaries and fallopian tubes during the colon procedure without the patient's specific consent. The surgeon thought that the patient's ovaries and fallopian tubes would need to be removed, and that it was more convenient for the patient to perform the procedure whilst she was already in theatre.

Was the surgeon justified? No. The consent the patient provided was only valid with respect to the colon operation. As the surgeon had also removed the fallopian tubes and ovaries without the patient's consent, he could potentially be guilty of trespass to the person and found negligent. A patient must provide specific consent for each medical procedure unless the circumstances fall within a legally authorised exception to the rule, such as an emergency.

4.3.4. Informed

The patient must be informed in broad terms of the nature and purpose of the healthcare in a way the patient can understand.

Health Practitioners have a duty to provide the patient with enough information to enable them to gain a genuine understanding of the nature and effects of the operation, procedure or treatment, the risks associated with it and any alternatives to the proposed treatment.

The information provided to the patient as part of the consent process should take into account the patient's Health Literacy to ensure that it is understandable. This obligation includes the use of different communication tools as necessary, including shared decision making.

Further guidance

- Section 4.8 – How do I properly inform a patient about a procedure and warn of material risks?
- NSW Health Clinical Excellence Commission *Health Literacy Framework*

4.4. Does the consent need to be in writing?

The general law on consent does not require consent or the provision of information, including warnings about risks, to be in writing. Consent to the treatment or procedure must still be sought notwithstanding it is not always required in writing. 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 freely hold out their arm to receive an injection and this action could imply their consent.

However, a written consent, using the consent forms attached to this Consent Manual (Attachments A-F) (or an electronic equivalent as discussed in section 4.11.1) will assist Health Practitioners in providing appropriate and adequate information to patients in line with community expectations and legal requirements.

Written consent must be obtained for significant treatment and procedures as set out at section 4.5. Written consent should also be sought where a Person Responsible is consenting to treatment on behalf of a patient. There are some exceptions to this set out at section 7.5.

Written consent may also assist if there are subsequent legal proceedings questioning the validity of consent. In such cases, written consent will provide strong contemporaneous evidence of what was discussed and the patient's consent and views. While a written consent is not a legal document, it can be used in legal proceedings as evidence. The absence of a written record of consent could give rise to the inference that the procedure has not been discussed or that consent has not been obtained.

Regardless of how consent is obtained it is important to make a note in the patient's Health Record. If there is a particular reason why consent was not obtained in writing, this should also be documented, as should any involvement of an accredited interpreter.

Further guidance

- Section 4.8.4 – Patient information forms, brochures or other prepared material about a treatment to inform a patient when obtaining consent
- NSW Health Policy Directive *Clinical Procedure Safety* (PD2017_032)
- NSW Civil and Administrative Tribunal, Guardianship Division *Consent to Medical or Dental Treatment Factsheet*

4.5. Significant procedures or treatments requiring written consent

The NSW Health consent forms attached to this Consent Manual (or an electronic equivalent as discussed in Section 4.11.1) must be used for significant treatment or procedures. Whether a procedure is regarded as 'significant' will be a matter of clinical judgment depending on the circumstances. Health Practitioners should have regard to local policies and procedures for consent requirements. As a guide, significant procedures include:

- all operations (excluding minor procedures)
- all procedures requiring general, spinal, epidural, or regional anaesthesia or intravenous sedation
- any invasive procedure or treatment where there are known significant risks (including rare but important risks) or complications (for example, insertion of a chest drain or central lines and any procedure involving penetration of the peritoneum, thoracic cavity, pericardium, epidural space, spinal canal or cranial cavity)
- blood transfusions or the administration of blood products (see NSW Health Policy Directive *Blood Management* (PD2018_042))
- any treatment for which the approval of a Human Research Ethics Committee (HREC) is required. Note that a Person Responsible cannot consent to treatment pursuant to a clinical trial unless the trial has been approved by the Guardianship Division of the NCAT
- where a written consent form is required as a condition of a special approval process for the provision of certain medical treatment (for example, provision of medical treatment under the Commonwealth Government Therapeutic Goods Administration Special Access Scheme may require written consent on an approved consent form)
- significant treatment which might pose a risk to the health of the patient (for example, cardiac catheterisation, antineoplastic agents (for example chemotherapy), or radiation therapy).

Significant procedures are also referred to as Level 2 or 3 clinical procedures for the purposes of NSW Health Policy Directive *Clinical Procedure Safety* (PD2017_032).

Further guidance

- Commonwealth Department of Health, Therapeutic Goods Administration *Special Access Scheme*.

4.6. Minor procedures or treatments

Unless local policies or profession specific standards require written consent, signed consent forms are not required for minor procedures. Minor procedures include brief procedures performed under local anaesthesia, insertion of IV cannulae, urethral catheterisation, or suture of minor lacerations.

Although a signed consent form is not required for minor procedures, the criteria for obtaining a valid consent must still be met. That is, the patient must have capacity to consent, the consent must be freely given and be sufficiently specific to the treatment, and the patient must be informed about the procedure and any material risks.

It is important that a patient's consent to a minor procedure is recorded in the patient's Health Record if a signed consent form is not used.

4.7. Patient consent forms and Health Records

Where a consent form, or other form referred to in this Consent Manual, is used, it should remain as a separate stand-alone form in the patient's Health Record. This does not prevent 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 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. A copy of the consent form may be provided to the patient.

A consent form or record of consent is an essential element of care. The form and entries in the patient's Health Record should be clear and legible. The use of abbreviations and symbols on consent forms is only permitted when these are clearly understood by the patient (for example, CPR).

A consent form can be uploaded into an electronic medical records system by scanning the form into an appropriate human readable and reproducible format and loading into a medical record system so that it can be readily located, viewed and printed as part of the electronic medical record. Typical formats include jpeg, tiff and pdf.

The elements of a valid consent must still be met when using an electronic consent form.

Further guidance

- Section 4.11.1 - Capturing consent electronically
- NSW Health Policy Directive *Health Care Records - Documentation and Management* (PD2012_069)

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

In order to be valid, consent must be informed. This requires the Health Practitioner to provide the patient with enough information to enable them to gain a genuine understanding of the:

- nature of the condition being treated
- proposed procedure or treatment and expected outcomes
- material risks and benefits of the proposed treatment, including alternative choices and whether the evidence supports one option over another.

Failing to warn a patient about the material risks of a proposed procedure could be a breach of the Health Practitioner's duty of care to the patient and could give rise to legal action for negligence.

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. A risk is also material if the Health Practitioner is, or should reasonably be aware, that a particular patient, if warned of the risk, would be likely to attach significance to it. It is important for Health Practitioners to explore what specific information is likely to be significant to each patient.

Information should be provided to the patient in a way which recognises the patient's Health Literacy level. A patient's Health Literacy can be improved by simplifying information, checking in to ensure understanding and supporting people to self-manage their health or use supported decision making where appropriate.

Careful consideration must also be given to using trauma-informed care principles and ensuring that the information provided enables a genuine, empowered choice.

Example

The patient's situation: A 33-year-old man is having back surgery to alleviate pain in his lower spine as a result of a protruding disc. The man works as a hairdresser and is a single father of three young children. He has told his surgeon that he can cope with the pain although he hopes that the operation might reduce the pain and possibly allow him to engage in more exercise. He has emphasised that he cannot take more than 8 weeks leave from his job as he is the sole income provider for his family.

The risk: The operation carries a 1 in 1000 risk of spinal nerve damage leading to leg and muscle weakness which can take up to 12 months to repair with rehabilitation.

What should the patient be told? The surgeon has a duty to inform the patient of the risk (among other risks including ongoing pain and non-resolution of symptoms) of damage to the spinal nerves even though it is considered to be extremely rare. The risk is material to the man's decision to undergo the surgery because of his career as a hairdresser and his role as sole parent of three young children.

The patient has conveyed information regarding his situation to the surgeon, which should be factored into the surgeon's consideration of what is material to this patient and this patient's circumstances. It is also relevant that the patient's current situation, although not ideal, is tolerable. Therefore, even an unlikely risk of severe nerve damage requiring 12 months of rehabilitation might deter him from proceeding with the surgery – making it material to this patient.

4.8.1. Treatment or procedures that are outside accepted practice/contrary to clinical guidelines

If a Health Practitioner is aware that the proposed treatment or procedure is:

- outside accepted practice
- likely to be different from treatment that would be offered by their peers in the same clinical setting
- contrary to relevant clinical guidelines; or
- an off-label use/contrary to the manufacturer's indication for use,

there is a particular onus to draw this to the patient's attention. The Health Practitioner must explain the clinical rationale for choosing that treatment or procedure as part of the consent process. This, and any discussion relevant to the patient's decision to proceed, should be documented in the Health Record.

4.8.2. Treatment or procedures that involve new technologies or techniques, or technologies or techniques new to the Health Practitioner(s)

Where a Health Practitioner is proposing a new or novel procedure, such as a procedure using a new technology or device, the Health Practitioner must inform the patient that the procedure or treatment is new to their practice and provide the patient with details of their previous (potentially limited) experience with the procedure or treatment as part of the consent process. This discussion should be documented in the Health Record. The discussions should include:

- the risks and benefits of the new technologies or techniques
- that there may be unforeseeable or unknown risks or outcomes due to the experimental, un-validated nature of the procedure
- evidence or lack of evidence regarding the treatment or technique.

Health Services should have processes in place to ensure that a patient who decides not to consent to a new procedure can be offered alternative treatment.

Further guidance

- NSW Health Guideline *NSW Framework for New Health Technologies and Specialised Services* (GL2018_023)

4.8.3. Guidelines for informing patients about the risks associated with medical treatment

As a guide, Health Practitioner's advising patients about proposed treatment should consider discussing:¹

- the possible or likely nature of the illness
- 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, if novel or experimental, that some of the risks may be unknown
 - who will undertake the intervention
- alternative options for diagnosis and treatment
- the benefits and risks of different options, including options to defer the decision
- the degree of uncertainty of the diagnosis and any therapeutic outcome
- the likely outcome of not having the diagnostic procedure or treatment, or of not having any procedure or treatment at all
- the likelihood of complete resolution of the clinical problem and symptoms, or chance of improvement and chance of recurrence
- level of evidence for proposed intervention
- location of procedure and length of stay
- expected timeframe for recovery
- option of seeking a second opinion
- any significant long-term physical, emotional, mental, social, sexual, or other outcome which may be associated with the proposed intervention
- where the treatment involves an 'implantable device' (such as vaginal mesh, breast implants) the manufacturer's provided consumer information
- the time and cost involved, including any out-of-pocket expenses.

Clinical judgment about how to convey risks will be influenced by several 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 Health Literacy level and the patient's cognitive capacity
- accepted medical practice

The Health Practitioner should:

- communicate information and clinical opinions in a form the patient should be able to understand, using plain language, without any medical or technical jargon.
- allow the patient enough time to decide. The patient should be encouraged to reflect on opinions, ask more questions, and consult with their family, a friend or an advisor. The patient should be assisted in seeking another medical opinion where this is requested
- repeat key information to help the patient understand and remember it
- give written information or use diagrams/pictures/photos, where appropriate, in addition to talking to the patient
- pay careful attention to the patient's responses to help identify what has or has not been understood
- use a competent, registered interpreter when the patient is not fluent in English or use AUSLAN sign interpreter if required.

¹ The National Health and Medical Research Council (NHMRC) Guidelines, *General Guidelines for Medical Practitioners on Providing Information to Patients 1993, revised 2004, (now rescinded, however the advice remains relevant and appropriate.)*

4.8.4. Patient information forms, brochures or other prepared material about a treatment to inform a patient when obtaining consent

Prepared material about a procedure or treatment can be useful as a means of stimulating discussion and for guiding the Health Practitioner when informing the patient.

Prepared material should:

- be up to date, accurate and appropriate for the patient
- be in plain language (Easy English) that is easy to understand or translate
- contain all inherent risks of the procedure. If a risk is more likely and/or has significant consequences, additional detail should be included
- ideally be provided before meeting with the patient to give the patient time to consider the information and prepare questions for the Health Practitioner
- be available in a variety of languages and formats (for example, large print).

Providing prepared material, without discussion, will not be enough to discharge the Health Practitioner's duty to fully inform the patient about the proposed treatment. The Health Practitioner should assist the patient to understand the material and provide further explanation if required. Health Practitioners should also check that information is up to date and accurate. An inadequate, inaccurate or out-dated information sheet may undermine the assertion that a patient has been properly informed.

If a patient is provided with a copy of prepared material as part of obtaining consent, this should be recorded in the Health Record and, ideally, a copy of the prepared material attached to the consent form.

4.8.5. Aboriginal Patients

NSW Health Policy Directive *Aboriginal and Torres Strait Islander Origin – recording of Information of Patients and Clients* (PD2012_042) outlines the requirements for collecting and recording accurate information on whether clients of NSW Health services are Aboriginal and/or Torres Strait Islander. If the patient identifies as Aboriginal and/or Torres Strait Islander, they should be offered the services of an Aboriginal Hospital Liaison Officer or Aboriginal Health Worker where available.

Acknowledgement and understanding of cultural sensitivities may assist in discussions around consent to recommended medical treatment. The National Safety and Quality Health Standards (NSQHS) states that Aboriginal and Torres Strait Islander patients may have the capacity to make decisions but also choose to involve a substitute decision maker in the planning and care processes. Communication strategies need to be clear and interactive to enable culturally appropriate ways of working and sharing understandings to enable good clinical decision making. Communication should be respectful of culture, adhere to cultural protocols and respect Aboriginal and Torres Strait Islander knowledge.

In obtaining consent, clinicians should be aware of potential past and existing trauma experienced by Aboriginal patients. Ensuring trauma-informed practice means discussing consequences that are clearly connected to the behaviour, delivered with genuine empathy and respect. Trauma-informed practice uses words that encourage thinking, and preserve connections between people.

In addition, consideration should be given to the level of Health Literacy of Aboriginal patients. A range of factors are linked to each person, their environment and upbringing that can either support or interfere with the development of individual Health Literacy. In some cases, the likelihood of lower individual Health Literacy might be increased where disadvantage and vulnerabilities connect. Individual Health Literacy is also dynamic: it can fluctuate depending on issues such as illness, stress and where the person is in their life course.

Example

Sheree is a 30 year old Aboriginal mother with 3 young children at home in the care of her husband. A neighbour has brought her to a busy emergency department at 7:15am with a cut to her hand sustained while preparing breakfast. Sheree is briefly seen by the triage nurse, who assesses the wound as stable and not actively bleeding. However, Sheree is likely to need stitches. She is prioritised as acute but told there would be some waiting time because of more urgent cases.

Sheree is anxious and distressed. Her neighbour is concerned for her welfare and is also aware that Sheree's husband has an important meeting at work that morning. Frustrated with waiting, Sheree's neighbour asks hospital staff about alternative care available. The Aboriginal Hospital Liaison Officer (AHLO) is contacted who advises that care could be provided at the local Aboriginal Medical Service (AMS). The AHLO is able to assist Sheree in making a priority appointment. Sheree and her neighbour decide to leave with the intention of visiting the AMS as soon as the children are organised and leave for school.

The primary duty owed by the hospital in this scenario is to assign an appropriate priority through the triage process and to observe Sheree in the waiting area for any deterioration in her condition. The hospital's duty of care also extends to providing Sheree with clearly communicated and appropriate advice, and involving other hospital staff such as the AHLO where appropriate.

Further guidance

- The National Safety and Quality Health Service Standards, User Guide for Aboriginal and Torres Strait Islander Health, 2017
- NSW Health Policy Directive – Aboriginal and Torres Strait Islander Origin – Recording of Information of Patients and Clients (PD2012_042)
- NSW Health Policy Directive – Emergency Department Patients Awaiting Care (PD2018_010)

4.8.6. Patients from culturally and linguistically diverse (CALD) backgrounds

Facilitating conversations and treatment decisions with patients from a range of diverse cultural and linguistic backgrounds can be challenging in a health care setting, where complex concepts, procedures, risks and alternative outcomes must be communicated. Health Practitioners should consider the patient's culture and trauma experience and how that might impact the consent process. Asking a patient what matters most to them may assist in understanding their health care needs.

NSW Health policy requires the use of accredited interpreters (in person or by telephone) when obtaining consent from patients who are not fluent in English or whose preferred language is a language other than English for significant treatment or any procedure where written consent is required. Any consent obtained without the presence of an accredited interpreter where an interpreter is required may be invalid. Consent for treatment of patients who are not fluent in English, or whose preferred language is not English, may not be valid if it is obtained through a child, family member, other patient, visitor or non-accredited staff member acting as an interpreter.

Bilingual Health Practitioners who are highly proficient in a language other than English may consult and communicate directly with their patients in the ordinary course of patient care. This is to be distinguished from interpreting. In these cases, the Health Practitioner must make a professional assessment that they can fully discharge their professional duty with regard to obtaining the patient's consent to the procedure or treatment in the patient's preferred language, for example, where a Health Practitioner is fluent in the patient's language. An appropriate notation should be made in the patient's Health Record and on the consent form that consent was sought by the practitioner in the patient's native tongue. The Health Practitioner in this situation would not be the interpreter for the purposes of the consent form.

Where a Medical Practitioner seeks consent in their private rooms for a procedure to be performed in a public hospital, the same requirements to use an accredited interpreter apply.

Example

A 45-year-old woman, Latika, arrives at the hospital for a hysterectomy. She speaks only basic English. A signed consent form is on Latika's Health Record along with an information sheet for her operation, which is written in English. On inspection, there is no record of an interpreter having been present at the consultation and no indication that any information has been provided in Latika's first language.

On the information available, the signed consent form in the file would not be valid. Latika should be re-consented by the admitting surgeon before the surgery with an interpreter present. This process should ensure a complete discussion of risks, benefits and possible side effects as well as alternatives to the treatment. If the surgeon is bilingual and decides they can communicate directly with the patient in her language to obtain consent, this should be documented.

As surgery is a significant treatment or procedure, the consent must be in writing and should be signed by the surgeon as well as the interpreter and the patient and filed on the patient's Health Record. A copy can be provided to Latika if requested.

Further guidance

- NSW Health Policy Directive *Standard Procedures for Working with Health Care Interpreters* (PD2017_044)

4.8.7. Other communication difficulties (sensory and communication disability)

Some patients may have a sensory disability (for example, they may be deaf, hearing impaired, blind and/or vision impaired) or have a communication disability (for example, impairment of language or complex communication needs). In these cases, the Health Practitioner should rely on appropriate communication aids according to the circumstances. For example, information about Auslan sign language interpreters is available from the Health Care Interpreter Service.

The law requires Health Services to make 'reasonable adjustments' to support inclusive and accessible services to people with a disability. Failure to make reasonable adjustments may be discrimination. In a health care setting in the context of obtaining consent, some examples of reasonable adjustment could include:

- adjusting communication methods by considering the patient's communication needs. This could include using tablets, low vision aids, speech generating devices or a cues book
- including and supporting the patient's carer, family member, guardian or disability support staff as expert care partners
- additional consultation to allow ample time for understanding and reading provided information
- providing patient information in alternate formats such as easy read documents.

The NSW Council for Intellectual Disability *Consent to Medical Treatment Fact Sheet* gives the following advice to assist Health Practitioners when seeking consent from a patient with an intellectual disability in ensuring the person understands and can make their own decision:

- involve someone who the person likes talking to
- talk about the treatment somewhere that is quiet and where the person feels relaxed
- try to use words the person knows. If you have to use difficult words, try to explain them simply
- if the person has an alternative communication system, use that
- use pictures or diagrams that show the problem and the proposed treatment
- stick to the basic information. Do not overload the person with detail; and
- give the person time to think about the information, ask questions, and then have another talk.

Further guidance

- [AUSLAN](#)
- NSW Health Policy Directive *Responding to Needs of People with Disability during Hospitalisation* (PD2017_001)
- NSW Health Policy Directive *Provision of Services to People with an Intellectual Disability and Mental Illness – MoU and Guidelines* (PD2011_001)
- The NSW Council for Intellectual Disability *Consent to Medical Treatment Fact Sheet*.
- Department of Communities and Justice *A NSW Government agency guide for effective communication for people with a sensory disability*.

4.9. Can information be withheld from the patient?

There are two (2) situations where a Medical Practitioner may be justified in withholding information from a patient.

1. *Where a patient does not want the information* and expressly directs the treating Medical Practitioner to make decisions on their behalf. Even in this case, the Medical Practitioner should give the patient basic information about the diagnosis and treatment. Any direction or views expressed by the patient must be documented in the patient's Health Record.
2. *Therapeutic privilege*. Information could be withheld in rare circumstances where the Medical Practitioner holds a reasonable belief that providing information would be damaging to the patient's health. This will only arise in very limited circumstances and requires the Medical Practitioner to make a judgment, based 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. In these circumstances, the Medical Practitioner should clearly record the reasons for exercising therapeutic privilege in the patient's Health Record. Health Practitioners should consider seeking assistance in communicating with patients and families about difficult matters and consult with colleagues before making a decision on withholding information.

Information cannot be withheld from a guardian or Person Responsible making decisions on behalf of a patient under the *Guardianship Act 1987*. Where it is considered that the Person Responsible is not capable of performing their functions the Medical Practitioner should certify this in writing and the next person in the Person Responsible hierarchy should be consulted.

Further advice should be sought from Ministry of Health Legal Branch or the local Director of Medical Services if there is any uncertainty about whether information can be withheld from a patient.

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

Some treatments involve several separate procedures or the administration of medication or blood products over a period of time or a series of patient visits. Antineoplastic agents (for example, chemotherapy) and the administration of blood products to patients with haemophilia are examples of a treatment program. Wound therapy dressing changes could also be considered a treatment program.

Consent to undergo the treatment program should be obtained and documented before beginning the course of treatment. An explanation of the treatment program, including the proposed duration of the program, the steps or separate treatments/procedures involved, and the material risks associated with the treatment program should be provided. A further consent form for each stage of the treatment program will generally not be necessary.

A new consent 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.

Health Practitioners should also 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 Health Record. If the issues raised are significant, or result in a material change to the treatment program, a new form should be completed to capture the discussions.

An unexpected change to a patient's treatment cannot be part of a 'treatment program'. For example, if a patient consents to surgery, and after that surgery has been performed, requires to be returned to theatre as a result of a complication such as a post-surgical bleed, a new consent should be obtained, unless the situation is an emergency and consent is therefore not required, or cannot be obtained in the circumstances.

4.11. Can consent be captured electronically, and can a consent form be faxed or emailed?

4.11.1. Capturing consent electronically

Some electronic medical records programs have capability to capture the patient's consent to a proposed treatment or procedure. It is important to remember that the elements or four criteria of a valid consent must be met regardless of the method used to capture consent.

Further, whilst there are no legal barriers to capturing consent electronically, processes must be in place to maintain the integrity of the electronic record. For example, electronic records should be protected from being corrupted from any changes to software.

There are some other important issues to consider:

- Information provided to a patient as part of obtaining consent must be documented. This can be achieved a number of ways, depending on the electronic medical records program in use - through free text typing by the Health Practitioner, uploading a voice recording of the Health Practitioner advising the patient about the procedures and material risks, or using a pamphlet as part of the information provision and then uploading it or uploading a photo of the pamphlet in the electronic medical record.
- If the facilities are available to the Health Service, the patient may be provided with an electronic device and use a compatible instrument to manually sign the device to signify consent. Also, a patient's voice recording giving consent may be uploaded to the Health Record. These recordings must be clearly linked to the treatment the patient is consenting to and must be readily accessible in the patient's Health Record.
- There must be processes in place to verify the identity of the patient or the patient's Person Responsible either through a photo identification or Patient Identifier (including patient identification bands) before consent being recorded. The Health Service must ensure that the electronically recorded consent is as reliable as the hard copy version in terms of security, storage and access. If exceptional circumstances arise whereby the Person Responsible is providing consent over the telephone, there must be a local level policy in place to confirm the identity of the Person Responsible and their connection to the patient. This could include asking standard questions to confirm the Person Responsible's personal information. The details of identity confirmation must be documented in the patient's Health Record.
- The user interface elements must indicate that the Health Practitioner had a discussion around the proposed treatment, material risks and consequences. The act of checking or ticking the user interface element(s) to indicate what was discussed and that valid consent was obtained must record the user that performed that action in a permanent log, together with time and date stamps.
- A physically signed, hard copy consent form may be uploaded in an appropriate human readable format to form part of the patient's electronic medical record. Examples of electronic formats include jpeg and pdf.
- If subsequent changes to the state or content of any user interface elements or scanned documents are allowed, the user interface must indicate clearly that changes have been made without any action required by the viewer and must log all changes with clear identification of the user making the change and the date and time of each change. Where changes are made to a scanned document and a new version is created, the original scanned copy must be retained for medico-legal reasons.

4.11.2. Faxed, emailed, photocopied consent forms and the use of electronic signatures

An original consent form should be obtained where possible as it is preferable to a faxed, photocopied or scanned and emailed form. If it is not possible to obtain an original consent form, a faxed, photocopied or scanned version can be retained, provided it is of reasonable quality and it is possible to verify the signature of the patient/Person Responsible. When faxing, copying or scanning consent forms, care should be taken to ensure that double-sided documents are captured in their entirety.

The use of a stamp signature or electronic equivalent signature as part of the consent process should be discouraged as they make it difficult to verify whether the Health Practitioner signed the documentation or whether it was stamped by someone else. The use of these methods could be used later to call into question whether the Health Practitioner actually turned their mind to making that decision.

Further guidance

- NSW Health Policy Directive *Health Care Records – Documentation and Management* (PD2012_069)

4.12. 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.

Some examples of situations which could mean that the patient's circumstances have changed materially and require a new consent (either using a new form or simply recording the consent in the Health Record) are as follows:

- where a patient who was incapable of providing their own consent becomes well enough and capable to provide consent to future care and treatment
- the development of alternative treatments to the recommended procedure
- the identification of new risks or side effects associated with the recommended procedure
- where consent was provided 12 months ago for a major procedure but there may be unrecognised cognitive changes in the patient.

Consent should also be revisited 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 including the procedure for which consent is sought.

Example

A patient signs a consent form to undergo an elective septoplasty (surgery to correct a deviated septum). He is classified as urgency category 3 – surgery recommended within 365 days. When the patient is admitted to hospital for the surgery, 14 months have passed since the date that the consent form was signed. However, as the patient's health has not changed in that time, and there have been no changes in the way that the surgery will be performed, the consent form is still valid. Even so, the patient's consent should still be re-confirmed verbally by the operating surgeon immediately prior to the surgery.

Consents granted by the Guardianship Division of the NCAT or the Public Guardian will not usually have an unlimited timeframe. Consents will usually be valid for 3, 6 or 12 months depending on the nature of the proposed treatment. Patients subject to such consents should be reviewed before the expiry of the consent orders and, where necessary, a further application or request for consent should be made where treatment is to be continued or modified.

5. Who should obtain consent?

5.1. Who is legally responsible for obtaining a valid consent?

In general, the Medical Practitioner under whose care a patient is admitted (either as a public or private patient) and/or the Health Practitioner who performs the procedure will have, or will share, legal responsibility for the overall care of the patient. Where the Medical Practitioner recommends or advises that a patient undergo an operation, procedure or treatment, that Medical Practitioner has responsibility for obtaining a valid consent. This includes ensuring that the patient has sufficient, appropriate and relevant information and advice to enable the patient to make their own decision regarding the proposed operation, procedure or treatment.

Often, the Medical Practitioner who recommends a procedure does not perform the procedure. For example, the Admitting Medical Officer may delegate the task of performing the procedure to another Medical Practitioner or Health Practitioner, in accordance with hospital protocol.

Both the Admitting Medical Officer and the Medical Practitioner or Health Practitioner who ultimately performs the procedure have legal and professional responsibilities to the patient to obtain a valid consent. The extent of the legal responsibility of each practitioner will vary according to the facts and circumstances of each situation considering the complexity and seriousness of the procedure or treatment.

Ultimately, before performing the procedure or treatment, the Medical Practitioner or Health Practitioner performing the procedure or administering the treatment needs to be satisfied that:

- the appropriate procedure or treatment has been requested for the patient; and
- the patient has been provided with the necessary information regarding the material and inherent risks of the procedure or treatment for a valid consent.

5.2. Other Health Practitioners obtaining consent

In most cases, the Health Practitioner who will perform the procedure, or provide the treatment should obtain or confirm the patient's consent for that procedure or treatment. Health Practitioners such as Nurse Practitioners and Midwives, and allied health professionals perform procedures and some examinations as part of their usual scope of practice, such as central line insertion, lumbar puncture, and abdominal paracentesis. Any Health Practitioner who is appropriately experienced and trained to perform procedures within their scope of practice must obtain a valid consent prior to performing those procedures. Consent may be implied from the patient acquiescing to the procedure. 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 Health Record documenting this.

In cases where treatment is being provided by Health Practitioners other than Medical Practitioners, including *Significant procedures or treatments requiring written consent* (section 4.5), those Health Practitioners may obtain written consent and use the consent forms in this Consent Manual. In these circumstances, references in this Consent Manual and on the consent forms to Medical Practitioners should be read as also applying to Health Practitioners more broadly.

Health Practitioners must also obtain written consent where other policies and procedures mandate a written consent, for example, Sexual Assault Forensic Examinations. Written consent may also be considered where the Health Practitioner considers the risks of the procedure are material or the circumstances warrant written consent.

In some cases, an Admitting Medical Officer may inform the patient and obtain verbal consent for a procedure or treatment that will be performed or provided by a Medical Practitioner but ask that a Nurse or Midwife or administrative staff have the patient complete and sign the consent form. In these instances, the Admitting Medical Officer is still required to complete the 'Provision of Information to Patient' section on the consent form. This practice should not be encouraged, and it should be documented that the Nurse or Midwife or administrative staff member is not seeking consent but rather having the patient confirm the consent given to the Admitting Medical Officer.

Providing information

All Health Practitioners are under a general duty to exercise reasonable care where they provide any advice or information to a patient. In circumstances where information is sought from a Health Practitioner who is not the Medical Practitioner responsible for ensuring that the patient is appropriately informed about a procedure and seeking consent, the Health Practitioner should ensure that any additional advice is accurate and documented in the patient's Health Record.

If a Health Practitioner becomes concerned that the patient has not been provided with enough information about the procedure, operation or treatment to have made a valid decision to undergo that operation, procedure or treatment, the Health Practitioner should take reasonable steps to ensure the patient receives the necessary additional information from the treating Medical Practitioner.

5.3. Can the task of obtaining a valid consent be delegated to a Junior Medical Officer?

The task of providing the necessary information to patients to obtain a valid consent may be delegated by a senior Medical Practitioner to a Junior Medical Officer in certain circumstances, having regard to:

- the respective legal obligations of hospitals (independently and through its staff) and Medical Practitioners arising from the admission status of patients,
- the rights and expectations of patients
- the appropriate use of Medical Practitioner time and hospital resources.

An Admitting Medical Officer may delegate the task of obtaining a valid consent to a Junior Medical Officer in the following circumstances:

- the Admitting Medical Officer is satisfied that the Junior Medical Officer has the necessary skills and experience to inform the patient and obtain valid consent. Ideally, the Junior Medical Officer should have, on previous occasions and under the supervision of an Admitting Medical Officer, competently undertaken the task of obtaining consent from a patient in similar circumstances
- the Junior Medical Officer does not object to undertaking the task. Junior Medical Officers have a responsibility to refuse to undertake the task if they do not consider they have sufficient skill or experience. Decisions in this regard must be respected
- the Junior Medical Officer understands the procedure and can explain the risks and benefits and has ideally previously performed the procedure
- the procedure is routine.

Public patients should know which Medical Practitioner the hospital has arranged to be primarily responsible for their care. The issue of which Medical Practitioner will be performing the procedure should be canvassed with the patient at the time of providing information and obtaining consent. In some circumstances, the Medical Practitioner who will be performing the procedure will not have been nominated by the hospital at the time of obtaining consent from the patient. In this situation, the hospital should take steps to advise the patient of the name and position of the Medical Practitioner once such nomination occurs.

5.4. Admission from a Medical Practitioner's private rooms

Prior to admission to a public hospital, a patient who is seen by an Admitting Medical Officer in their private rooms should be provided with the necessary information about the procedure, including information about the material risks involved. The Admitting Medical Officer should also satisfy themselves as to the other requirements for obtaining a valid consent.

The relevant sections of the consent form should be completed by the Admitting Medical Officer 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:

- 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 Medical Practitioner's private rooms, for example, where an interpreter has been in attendance. Where this occurs, care should be taken to ensure that the patient is not pressured or rushed into signing the form
- Where the patient wishes to have more time to consider the proposed treatment, the Admitting Medical Officer should sign the relevant parts of the form and provide the form to the patient who can complete it later. In this case, the patient should be made aware that the procedure will not be undertaken until a completed consent form is produced

Hospital admissions staff should be aware that admission may be arranged through the Admitting Medical Officer's private rooms, without the patient having been seen at the hospital. This situation may arise in the case of recurring conditions or long-term treatment programs. In this case, the information will be provided to the patient in the Admitting Medical Officer's private rooms and consent will be sought at that time.

Admitting Medical Officers should consider, having regard to the nature of the proposed procedure and the risks involved, whether consultation with another Medical Practitioner is required for the patient. For example, where the risks of anaesthesia need to be explained by the attending anaesthetist or where the Admitting Medical Officer is not actually performing the procedure, the Medical Practitioner undertaking the procedure may need to consult with the patient.

There may be circumstances where the Admitting Medical Officer may request another senior Medical Practitioner to obtain consent from a private patient, including where the Admitting Medical Officer is unable to obtain consent personally or where the procedure is required as a matter of urgency. The Admitting Medical Officer must be satisfied that the delegated Medical Practitioner has the necessary skills and experience to inform the patient and obtain a valid consent and the delegated Medical Practitioner should agree to undertake the task.

5.5. Admission through the hospital emergency or outpatient department

Where a patient is admitted through the emergency department, the Admitting Medical Officer or Junior Medical Officer involved in admitting the patient should inform the patient of the proposed treatment, 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 before any pre-operative medication being given and before the operation, procedure or treatment.

Subject to the criteria in section 5.3 being met, outpatients being booked for elective procedures/treatments may be informed by a Junior Medical Officer who shall complete the patient consent form and ensure that patient consent is obtained. Such patients should be advised by the Junior Medical Officer that they will not necessarily be carrying out the procedure when the patient is admitted.

6. Refusal of treatment

6.1. Can a patient refuse treatment?

An adult patient with capacity has the right to refuse any medical treatment, even where that decision may lead to their death or the death of their unborn baby. This right exists even where the reasons for making the choice seem irrational, are unknown or even non-existent. The right to refuse treatment extends to all medical treatment including but not limited to ventilation, cardio-pulmonary resuscitation (CPR), dialysis, antibiotics and artificial feeding and hydration. Treating a person who has validly refused treatment could constitute an assault or battery.

Like consent to medical treatment, a refusal of treatment must be:

- freely given
- specific; and
- informed.

Where refusal of the recommended treatment is likely to have serious consequences for the health or wellbeing of the patient, consideration should be given to assessing the patient's capacity to refuse the treatment. Efforts should be made to ascertain the reasons for the refusal and whether these can be addressed by providing alternative treatment or by other means (such as by ensuring the treatment is provided by female Medical Practitioners only, if practicable). Sensitive cultural and religious issues should be accommodated where possible, for example, non-blood products for Jehovah's Witnesses.

There are some limited scenarios where a patient who would otherwise be considered to have capacity cannot lawfully refuse treatment, for example when patients are subject to certain mental health orders.

All instances of refusal of treatment must be noted in the patient's Health Record. Ideally, the patient should sign a *Procedure/Treatment Refusal Acknowledgement (Patient with Capacity)* form. Where the refusal of treatment may lead to harm and/or death, these consequences must be explained and documented. The *Procedure/Treatment Refusal Acknowledgement (Patient with Capacity)* form does not need to be used where the risks of refusing treatment are low.

There is no *Procedure/Treatment Refusal Acknowledgement* form for Minors. Where a parent or guardian is refusing treatment on behalf of a Minor, the Health Practitioner must consider the risk of significant harm arising from the refusal of treatment and the obligations under the *Children and Young Persons (Care and Protection) Act 1998*. The refusal and steps taken to try to reach agreement about treatment should be documented in the Health Record. Refer to sections 8.4 and 8.5 of this Consent Manual for further guidance.

There is also no *Procedure/Treatment Refusal Acknowledgement* form for adult patients without capacity. A Person Responsible can decide not to consent to a proposed treatment on behalf of an adult without capacity. Where agreement cannot be reached between the Health Service and the Person Responsible, consideration must be given to whether the Person Responsible or guardian is adequately making decisions that promote the patient's health and wellbeing and whether an application needs to be made to the Guardianship Division of NCAT seeking consent to the proposed treatment, or the appointment of an alternative substitute decision maker. The refusal and steps taken to reach agreement should be documented in the Health Record.

As with consent, if the patient's circumstances change significantly, the refusal may not remain valid and may need to be confirmed.

Refusal of treatment can be verbal, written or implied. In circumstances where the refusal of treatment may lead to death, or a serious deterioration of the patient's health, the refusal should be in writing and signed by the patient. It is also very important that, in these cases, the information communicated to the patient is documented clearly in the Health Record.

In circumstances where the patient no longer has capacity to consent to, or refuse medical treatment, and it is not an emergency, Health Practitioners are required by law to consult with and seek consent from the Person Responsible for the patient pursuant to the *Guardianship Act 1987*.

A guardian (including an Enduring Guardian) can consent to treatment being withheld or withdrawn if they have been expressly given such power in their appointment. It is important to review the terms under which guardians are appointed before making a decision and seek legal advice if you are unsure.

Where the treating team considers that life-sustaining treatment will have no clinical benefit, consent to withhold or withdraw treatment is not required from the patient or Person Responsible (including guardian or Enduring Guardian), however, Health Practitioners are encouraged to engage in discussions with the patient if possible, their Person Responsible and family to determine the patient's best interests.

Further guidance

- [NSW Civil and Administrative Tribunal, Guardianship Division, Person Responsible Factsheet](#)
- Section 10.2 – Information and Consent requirements for pregnancy and birth related procedures and interventions

Example

Li is a 25-year-old who has requested that the hospital cease her life-sustaining treatment including the withdrawal of ventilation. This is expected to lead to Li's death. Li has been ventilated for over five years but has recently been experiencing frequent and severe respiratory distress and is now unable to leave a hospital environment. Li has been assessed by several specialist Medical Practitioners as having capacity and as having arrived at the decision to refuse treatment in a deliberate and seemingly rational fashion and without any coercion. She has also recorded her wish in writing and provided it to her treating medical team.

Li is an adult who has been assessed by appropriate specialists as having capacity to make the decision to refuse life-sustaining treatment and is therefore entitled to do so.

The treating medical team would be advised to obtain advice from the Ministry of Health Legal Branch if there is any doubt regarding Li's capacity, or other concerns or complexities. If there is any uncertainty, the Supreme Court can be asked to make a declaration with respect to the refusal of treatment.

6.2. Refusal of treatment using an Advance Care Directive

6.2.1. What is an Advance Care Directive?

Advance Care Directives (ACDs) are a document recording decisions or value statements that describe the person's future preferences for receiving or refusing specific types of medical treatments. ACDs are to be used when the person loses capacity. An ACD is a type of advance planning tool that may only be completed by a person with decision-making capacity. It is recommended that an ACD be signed by the person.

Where a patient has a valid ACD (discussed below) then the decisions in the ACD must be respected (unless there is a power to provide treatment without consent, for example, a patient under mental health order).

A Person Responsible (including Enduring Guardian) cannot complete an ACD on behalf of another person. However, a Person Responsible for a patient without capacity may participate in Advance Care Planning discussions with the treating team.

There is no standard form or template for an ACD in NSW, although there are several documents in use, including a template available on the NSW Health website (see further guidance below). An ACD does not need to be in a particular format and does not need to have been witnessed. An ACD should not be confused with clinical care plans, treatment plans or resuscitation plans written by Medical Practitioners or appropriately qualified Health Practitioners.

If a patient has an ACD, it should be placed in the Health Record.

Further guidance

- [Planning Ahead Tools](#)
- [NSW Health Making an Advance Care Directive – form and information booklet](#)

6.2.2 How do I know that the Advance Care Directive is valid?

An ACD will be valid when it:

- has been made voluntarily by an adult with capacity
- is clear and unambiguous
- was intended to apply to the situation at hand.

An ACD can be valid even if the person giving it was not informed of the consequences of deciding in advance to refuse specified medical treatment. Decisions in an ACD can be based on religious, social or moral grounds. Directions do not have to be supported by rational reasons. An ACD can be valid as long as it was made voluntarily by an adult with capacity and in the absence of any overriding factor such as coercion.

If a patient has refused treatment in a valid ACD, their family or Person Responsible has no legal authority to override the ACD.

Example

Marianne is 42 and has been admitted to hospital, unconscious, following a car accident. She requires surgery to repair a shattered leg bone. Marianne's family present the treating team with an Advance Care Directive signed by Marianne refusing all treatment in relation to her dying from the motor neurone disease she was diagnosed with six months ago.

In this situation, as the ACD was not intended to apply to the situation at hand (being the car accident) and therefore cannot be relied upon to not undertake the surgery on Marianne's leg.

6.2.3. Do Advance Care Directives have to be followed in an emergency?

Where there is a known, available, and valid ACD, it cannot be overridden in an emergency. The patient must only receive treatment that is consistent with the ACD. If a patient presents with an ACD or other document that refuses treatment, a copy of the document should be made and placed on the patient's Health Record.

6.2.4. What if there is doubt about the validity of an Advance Care Directive?

Circumstances of genuine and reasonable doubt about the validity of an ACD may arise, including:

- whether the patient had capacity when it was written
- whether it was intended to apply to the current situation of the patient
- where the ACD is ambiguous or contains inherent inconsistencies.

In these circumstances, attempts should be made to obtain further information (for example, from the patient's family, General Practitioner, or a person who witnessed the ACD) about the circumstances of the ACD and whether it is still consistent with the patient's wishes. If this information does not resolve the ambiguity, legal advice can be sought from the Ministry of Health Legal Branch.

Cases where there is a suggestion of self-harm can be especially complex, and legal advice is recommended in these scenarios (see section 6.2.5 regarding mental health patients).

In cases where legal advice is being obtained, or guidance is being sought from a court, a Health Service and Health Practitioners are justified in treating the patient in the meantime, until the validity of the ACD is clarified. If there is delay in obtaining a copy of a patient's ACD, it is acceptable to treat the patient until the ACD document is available. Such treatment would be limited to emergency treatment, that is, treatment necessary to save an adult person's life, prevent serious injury to an adult person's health or alleviate significant pain or distress.

Example

Udit is a 60-year-old man who is admitted to the emergency department of a hospital with septic shock. Although appropriate medication is provided, he develops renal failure and within two weeks he is unconscious and being kept alive by mechanical ventilation and kidney dialysis in intensive care. His brother, Arjun, produces a written Advance Care Directive that he witnessed as being written and signed by Udit one year prior, which clearly indicates that Udit did not want to receive dialysis in the future. Arjun is worried Udit may not have understood the ramifications of his decision to refuse dialysis.

If an Advance Care Directive is made by an adult with capacity, is clear and unambiguous and extends to the situation at hand, it must be respected. In this situation the Medical Practitioner must be satisfied that the Advance Care Directive is genuine and valid, that is, that Udit wrote the document, he had capacity at the time the Advance Care Directive was made and it was made voluntarily. It is not necessary, in order for Udit's Advance Care Directive to be valid, that Udit should have been informed of the consequences of deciding, in advance, to refuse dialysis.

If Udit's Medical Practitioner has genuine and reasonable doubt as to the validity of the Advance Care Directive, it is appropriate to consult other family members or Udit's General Practitioner regarding his Advance Care Directive preferences. If doubt still remains, the Health Service should contact Ministry of Health Legal Branch as a matter of urgency to consider applying to the court for a determination as to the validity and operation of Udit's Advance Care Directive in the circumstances. The Medical Practitioner can continue to treat Udit while the validity of the Advance Care Directive is being determined.

6.2.5. What if the Advance Care Directive has been made by a patient experiencing mental ill-health?

In general, patients experiencing mental ill-health have the same rights with regard to making decisions about end of life care and Advance Care Planning as any other patient. However, the validity of the ACD may be called into question where:

- there is doubt regarding the capacity of the patient at the time of making the ACD; or
- there is any evidence the ACD was not made voluntarily.

However where a patient is detained under the *Mental Health Act 2007*, an ACD cannot override the power of an Authorised Medical Officer to authorise treatment.

Advice from the Ministry of Health Legal Branch is recommended in the above circumstances and a Health Practitioner would be justified in treating the patient in the meantime until the validity of the ACD is ascertained.

Further guidance (relating to Sections 6.2.1–6.2.5)

- [NSW Health Advance Care Planning and End of Life Decisions for People with a Mental Illness](#)
- Section 9 - Consent for patients being treated under the *Mental Health Act 2007*
- [NSW Health End of Life Decisions, the Law and Clinical Practice](#)
- NSW Health Policy Directive Using Resuscitation Plans in End of Life Decisions (PD2014_030)
- NSW Health Advance Planning for Quality Care at *End of Life Action Plan 2013-2018*
- NSW Health Guideline End of Life Care and Decision Making (GL2005_057)

6.3. Discharge against medical advice

A patient with capacity may decide to leave hospital against medical advice. However, as there have been cases where Health Services and Health Practitioners have been criticised and found negligent for not doing enough to convince patients to stay for treatment, it is important that attempts are made to engage the patient in a collaborative discussion indicating the reasons why the patient should stay, and the consequences of leaving so that the patient is making an informed decision. A Health Practitioner should, where circumstances reasonably allow, provide the patient with relevant information for ongoing treatment and care, which may include community care or referral to a General Practitioner. Health Practitioners should also reassure the patient that they may return to that facility or any other NSW Health facility at any time for further treatment and care.

These discussions should be well documented and where the patient or parent/guardian insists on leaving the health facility a *Discharge against Medical Advice* form should be signed, if appropriate.

A *Discharge against Medical Advice* form should not be used in the following circumstances:

- where the patient is aged over 16, does not have capacity and their Person Responsible or guardian is seeking to discharge them or refusing to stay for treatment. In these circumstances, consideration should be given to making an application to the Guardianship Division of NCAT or seeking legal advice
- where it is appropriate that the patient is admitted as an involuntary patient under the *Mental Health Act 2007*
- where a patient is a Minor and the relevant Health Practitioner reasonably suspects that the discharge of the patient against advice will put the patient at risk of significant harm (see section below regarding Minors and discharge against advice)
- where, in the professional opinion of the attending Health Practitioner, the discharge against advice does not pose actual risk to the patient in which case the patient leaving the facility can just be noted in the patient's Health Record
- where a patient 'did not wait' in the Emergency Department (see PD2018_010).

By signing a Discharge against Medical Advice form, the patient is acknowledging that they are leaving the health facility against medical advice and accepting responsibility for any consequences that flow from that decision. If a patient chooses not to sign a form, this should also be documented in the Health Record, including an outline of any discussion around the reasons for this.

If it is not practical to obtain and sign a Discharge Against Medical Advice form, the discussion about risks of leaving and follow up available can be recorded in the patient's Health Record.

Marginalised populations may have higher rates of discharge against medical advice, Health Services should regularly review whether improvements could be made to the experiences of the health service for these populations. Clinicians should adopt trauma informed care strategies and consider involving multi-disciplinary colleagues, for example, Aboriginal Health Liaison Officers, where appropriate.

Further guidance

- NSW Health Policy Directive *Departure of Emergency Department Patients* (PD2014_025)
- NSW Health Policy Directive *Health Care Records - Documentation and Management* (PD2012_069)
- NSW Health Policy Directive *Emergency Department Patients Awaiting Care* (PD2018_010)

Example

Tom is a 24-year-old male who arrives at a busy emergency department at 9.25pm with a broken arm sustained during an assault. He is with two friends who are very concerned for his welfare. Tom is briefly seen by the triage nurse and prioritised as acute but told there would be some waiting time because of more urgent cases. He is then seen by the Medical Officer who assesses Tom and provides some analgesia for his pain.

Later on, frustrated with waiting, Tom's friends ask hospital staff about alternative care available at that time of night and they decide to seek help elsewhere.

The primary duty which the hospital owes Tom in this scenario is to assign an appropriate priority through the triage process and to observe Tom in the waiting area for any deterioration of his condition. The hospital's duty of care also extends to providing Tom with appropriate advice if it is intimated that he is going to leave the waiting area. The Health Practitioners involved should advise Tom of the risks of leaving the hospital and reassess his condition with regard to his priority. If Tom insists on leaving the emergency department the Health Practitioner should inform him of any follow-up treatment and ensure he understands he may return to that hospital for further treatment at any time. This should be documented on the *Discharge against Medical Advice* form and signed by Tom.

Additional considerations with regard to Minors and Discharge against Advice

Health Practitioners should make all reasonable attempts to engage the parents or legal guardian in discussions regarding the risks to the patient of discharging against advice.

If the parents or legal guardian insist on leaving the health facility with the patient, the Health Practitioner should initially determine whether the action will pose a risk of significant harm to the patient. Where the relevant Health Practitioner reasonably suspects that the discharge of the patient against advice will put the patient at risk of significant harm the Health Practitioner must notify the Child Protection Helpline or the Child Wellbeing Unit and, where necessary, the Police in accordance with their legal obligations under Section 27 of the *Children and Young Persons (Care and Protection) Act 1998*.

If the Health Practitioner considers that the discharge against advice does not pose a risk of significant harm to the child but may still pose some additional health risks for the child, the Health Practitioner should consider notifying the Child Wellbeing Unit and request that the parents or guardian sign a *Discharge Against Medical Advice (for parents/guardians of Minors without capacity)* form.

The purpose of the form is to document the decision of a parent/guardian to discharge a patient at their own risk notwithstanding the knowledge of risks to the patient (as specified on the form) which have been explained to the parent/guardian by the most senior available Health Practitioner. The form also serves the purpose of alerting the parent/guardian to the potential for a suspected risk of significant harm report to the Child Wellbeing Unit where there are concerns regarding risks to the safety, welfare and wellbeing of a child or young person.

Generally, Mature Minors should not sign a *Discharge against Medical Advice* form on their own behalf. If a Mature Minor wishes to leave hospital against medical advice, the strategies in Section 8.5 should be considered. Advice from the Ministry of Health Legal Branch may be necessary.

Example

Max is a seven-year-old admitted patient who has been receiving treatment for burns to 20 percent of his body. He requires regular dressing changes and medical treatment by specialised Health Practitioners at the hospital. Max's parents are insisting he is discharged one week before his scheduled discharge date because of a family wedding. Max's Admitting Medical Officer has advised against discharging Max early and has had numerous discussions with Max's parents regarding the possible risks to Max's health if they insist on discharging Max against medical advice. However, this has not changed their minds.

The Admitting Medical Officer should assess the risks to Max's health posed by the parents' actions. If the Admitting Medical Officer reasonably suspects that the early discharge against advice will put Max at risk of significant harm, they must notify the Child Protection Helpline and follow the policies and procedures within *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* (PD 2013_007) and contact the Child Wellbeing Unit.

If the Admitting Medical Officer considers that the discharge against medical advice poses real risks to Max's health and wellbeing the Admitting Medical Officer should ask the parent to complete the appropriate Discharge Against Medical Advice form. The Admitting Medical Officer should document on the form the risks of discharge against advice which have been explained to Max's parents in their discussions. A follow-up treatment and care plan as explained to Max's parents should also be documented on the form.

The Admitting Medical Officer should also explain to the parents the potential for a suspected risk of significant harm report to the Child Wellbeing Unit where there are concerns regarding risks to the safety, welfare and wellbeing of a child or young person. When a report is made to the Child Protection Helpline or the Child Wellbeing Unit because the child is being discharged against medical advice, parents should generally be told before the report is made that the Health Service intends to notify the Department of Communities and Justice, unless doing so would place the child or any other person at risk.

It should be made clear to Max's parents that they may return to the hospital at any time for further care. The original signed form should be filed in Max's health record.

Further guidance

- NSW Health Policy Directive *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* (PD2013_007)
- NSW Department of Communities and Justice [NSW Mandatory Reporter Guide](#)

6.4. When can a Medical Practitioner or other Health Practitioner refuse to treat a patient?

6.4.1. Treatment of no therapeutic value

Medical Practitioners and other Health Practitioners are under no obligation to provide treatments that in their reasonable opinion are futile, that is, treatment that is unreasonable, offering negligible prospect of benefit to the patient.

If a patient (or their Person Responsible, or family members) is requesting treatment that is unlikely to provide any benefit, the Medical Practitioner should ensure that a discussion is held with the patient to explain why the treatment is considered to be of no therapeutic value, clarify the patient's prognosis and reach consensus on an appropriate treatment plan. Where the patient disagrees with the Medical Practitioner, a second medical opinion may be offered to assess the appropriateness of the treatment plan. The discussion and any second opinion should be documented in the patient's Health Record. Continued conflict with the patient or the patient's Person Responsible or family members following a second opinion should be escalated within the Local Health District or advice sought from Ministry of Health Legal Branch.

Conversely, Medical Practitioners who provide treatment that has no therapeutic value, such as unnecessary procedures, expose themselves to legal risk.

6.4.2. Conscientious objection

General

If a Medical Practitioner or other Health Practitioner has a conscientious objection to conducting a specific procedure or providing certain treatment to a patient, they should:

- inform the patient that they object to the provision of a procedure or treatment on ethical, moral or religious grounds and that other Health Practitioners may be prepared to provide the health service they seek
- take every reasonable step to direct the patient to another Medical Practitioner or Health Practitioner in the same profession who does not have the same objection.

Termination of pregnancy

The *Abortion Law Reform Act 2019* contains obligations for Health Practitioners with conscientious objections to performing, assisting or advising on a termination of pregnancy.

Further guidance

- NSW Health Policy Directive *Framework for Termination of Pregnancy in NSW* (PD2019_048)

6.4.3. Therapeutic relationship in disrepair

In rare circumstances, the therapeutic relationship between a Medical Practitioner or other Health Practitioner, or a treating team and a patient becomes difficult to manage.

Health Services have an obligation to treat all public patients based on clinical need. However, this obligation does not prevent the Health Service from implementing strategies such as transferring the patient to a different Health Practitioner, or to a different service if it is practicable to do so. In the circumstances of a patient transfer, the Health Practitioner should ensure that the necessary information is handed over to the new Health Practitioner. Details about the circumstances of the patient transfer should be recorded in the patient's Health Record.

7. Patients (16 years or over) who do not have capacity to consent

7.1. When does the *Guardianship Act* apply?

The *Guardianship Act 1987* applies to people aged 16 and over who are incapable of giving consent. The Act aims to ensure that people with a disability (such as an intellectual disability) are not deprived of necessary medical or dental treatment because they lack the capacity to consent to the carrying out of such treatment, and to ensure that any medical or dental treatment that is carried out on such people is carried out for the purpose of promoting and maintaining their health and wellbeing.

Consent for Minors aged 16 and 17 without capacity due to a disability can be obtained either under the *Guardianship Act 1987* or under the principles for consent for Minors in Section 8 of the Consent Manual.

7.2. The Person Responsible

The *Guardianship Act 1987* establishes who can give valid substitute consent when a person is unable to consent to medical or dental treatment.

Section 33(2) of the *Guardianship Act* states 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 they consent to the treatment.

When a patient lacks decision-making capacity and the treatment is not required in an emergency, Health Practitioners must obtain consent from the Person Responsible.

The Person Responsible for a patient will be:

1. An appointed guardian (including Enduring Guardian) with the function of consenting to medical and dental treatment. If there is no-one in this category;
2. A spouse or de facto spouse (including same-sex partners) who has a close and continuing relationship with the person. If there is no-one in this category;
3. The carer or person who provides or arranges domestic services and care regularly or did so before the person went into residential care, and who is unpaid (note: the carers pension does not count as payment). If there is no-one in this category;
4. A close friend or relative, provided they are not receiving remuneration for any services provided.

Health Practitioners have an obligation to consult with the person highest on the hierarchy. If that person is not present, attempts should be made to contact them. If a Person Responsible does not wish to make medical treatment decisions for a patient, or does not have capacity themselves, this must be documented in the patient's Health Record. If this happens, the next person on the hierarchy can be approached.

If there is no Person Responsible available, or the Medical Practitioner has concerns that the Person Responsible is not acting in the best interests of the patient and the treatment proposed is not minor or urgent, then an application can be made to the Guardianship Division of NCAT for the Tribunal's consent to the treatment, or for the Tribunal to appoint a guardian who can consent to the treatment.

7.3. What is a guardian or Enduring Guardian?

A person, 18 years of age or above, may appoint a guardian or Enduring Guardian using the prescribed form available from the Guardianship Division of the NCAT, or a form with the same features and effect.

An appointment only has effect during a period in which the person needs a guardian (when the person does not have capacity).

The decisions that an Enduring Guardian may make on behalf of the person are specified in the document appointing the person. The person appointing the Enduring Guardian may limit the decisions that they can make. Health Practitioners should ask to review the appointment document to ensure that the Enduring Guardian has the power to make decisions in relation to medical or dental treatment. Where there is a guardian appointed (enduring or appointed by NCAT) and that guardian has authority to consent to medical and dental treatments, only the guardian can perform that function and the rest of the hierarchy of Persons Responsible cannot. If the guardian is not available or willing to act, NCAT needs to be contacted. However, where the guardian does not hold the authority to consent to medical or dental treatments then the next person on the hierarchy should be contacted.

Further guidance

- NSW Office of the Public Guardian Factsheet *What is a Guardian?*
- NSW Civil and Administrative Tribunal, Guardianship Division, *Information for Applicants Appointment of a Financial manager and/or guardian*
- NSW Office of the Public Guardian *Substitute Consent what the law says*

7.4. What happens if a guardian or Enduring Guardian was appointed outside NSW?

If a person has been appointed as guardian of another person in another State or Territory or in New Zealand, that guardian can apply to NCAT to have their status as guardian recognised in NSW.

If a person has been appointed as an Enduring Guardian in another State or Territory, they can automatically make decisions in NSW without needing to apply for recognition. If an Enduring Guardian has been appointed overseas, the NCAT will need to recognise their status.

Further guidance

- NSW Trustee and Guardian, [Appointment of an Enduring Guardian form](#)
- NSW Civil and Administrative Tribunal, Guardianship Division, [Enduring Guardianship](#)
- Guardianship Regulation 2016, [regulation 8](#)

7.5. Requesting consent from the Person Responsible

A request to a Person Responsible for consent must specify the following information:

- the grounds on which it is alleged the patient does not have capacity to consent to medical treatment
- the particular condition of the patient that requires treatment
- the alternative courses of treatment that are available in relation to that condition
- the general nature and effect of each of the courses of treatment
- the nature and degree of the significant risks (if any) associated with each of these courses of treatment
- the reasons for which it is proposed that any particular course of treatment should be carried out.

These requirements will be met if the *Consent – Substitute Consent for Medical Procedure/Treatment* form is used and all fields are completed.

A request to a Person Responsible is to be made in writing. However:

- 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.
- 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 Responsible does not require the request for consent to be made in writing.

Where an oral request for consent is made for major treatment, it should be confirmed in writing using a *Consent – Substitute Consent for Medical Procedure/Treatment* form.

Health Practitioners must ensure that the Person Responsible has all the information they need to make an informed decision on behalf of the patient. In all cases, the Person Responsible must consider the views (if any) of the patient (including any objections the person may have to the treatment), the information provided by the person requesting consent and the objectives of the *Guardianship Act*.

A Health Practitioner who carries out treatment relying on the consent of a guardian or Person Responsible must keep a written record of the name of the person who gave consent, the date, any conditions on the consent and the treatment.

Further guidance

- NSW Civil and Administrative Tribunal, Guardianship Division, [Consent to Medical or Dental Treatment Application Form](#)
- NSW Health Guideline *The Guardianship Application Process for Adult Inpatients of NSW Health Facilities* (GL2016_026)
- NSW Public Guardian *Substitute Consent what the law says*
- NSW Public Guardian *Medical and Dental Treatment*

7.6. When is a consent application to the Guardianship Division of the Civil and Administrative Tribunal required?

An application to NCAT is required if one or more of the following apply:

- the treatment is Special Medical Treatment and it is not an emergency
- the treatment is major medical treatment or dental treatment and there is no Person Responsible or the Person Responsible is unable or unwilling to provide consent and it is not an emergency
- the patient is objecting to the proposed treatment (major or minor) and there is no appointed guardian authorised to override objections. In respect of minor treatment, NCAT approval is only required if the patient has no or minimal understanding of the treatment and the treatment will cause no distress or only some tolerable transitory distress (see section 7.9)
- the appointed guardian or Person Responsible is not acting in the patient's best interests. In this scenario, an application could also be made to the Supreme Court. It is recommended that advice from the Ministry of Health Legal Branch be sought prior to making an application to the Supreme Court.

Further guidance

- [NSW Civil and Administrative Tribunal, Guardianship Division](#)
- NSW Health Guideline *The Guardianship Application Process for Adult Inpatients of NSW Health Facilities* (GL2016_026)

7.7. Types of treatment under the *Guardianship Act* and consent requirements

The *Guardianship Act* makes different arrangements for obtaining consent depending on the level of intervention proposed. Distinctions are drawn between Minor treatment, Major treatment and Special Treatment.

Major treatment

In the *Guardianship Regulation*, major treatment is:

1. any treatment that involves the administration of a long-acting injectable hormonal substance for the purpose of contraception or menstrual regulation
2. any treatment that involves administration of a drug of addiction
3. any treatment that involves the administration of a general anaesthetic or other sedation, but not treatment involving:
 - sedation used to facilitate the management of fractured or dislocated limbs, or
 - 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.
4. any treatment used for the purpose of eliminating menstruation
5. any treatment that involves the administration of a restricted substance for the purpose of affecting the central nervous system, but not a treatment:
 - involving a substance that is intended to be used for analgesic, antipyretic, anti-Parkinsonian, anticonvulsant, antiemetic, anti-nauseant or antihistaminic purposes, or
 - that is to be given only once, or
 - that is a *pro re nata* (PRN) treatment (that is, given when required, according to the patient's needs that may be given not more than 3 times a month), or
 - given for sedation in minor medical procedures.
6. 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
7. any treatment involving testing for the HIV virus.

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

Consent by the Person Responsible to the carrying out of major medical treatment should generally be given in writing. However, it can be given orally if it is not practicable to do so in writing because of the need to provide treatment quickly. Where treatment proceeds based on oral consent, the consent must later be confirmed in writing using the *Consent – Substitute Consent for Medical Procedure/Treatment* form.

Minor treatment

Minor treatment is any medical or dental treatment which does not fall within the definition of Special Treatment or major medical treatment. Minor treatment does not include treatment administered in the course of a clinical trial.

Consent to minor medical treatment can be given by the Person Responsible. It should generally to be given in writing, but may be given orally if:

- it is not practical to give written consent, and
- the Person Responsible does not require it to be given in writing.

If there is no Person Responsible available or willing to give consent, minor treatment can proceed without consent. In such cases, the Health Practitioner carrying out the minor treatment is required to certify in writing in the patient's Health Record that the treatment is necessary and is the form of treatment that will most successfully promote the patient's health and wellbeing, and the patient does not object to the carrying out of the treatment.

Special Treatment

Special Treatment is defined as:

1. 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
2. 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
3. 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:

1. any treatment that is carried out for the purpose of terminating pregnancy,
2. any treatment in the nature of a vasectomy or tubal occlusion,
3. any treatment that involves the use of an aversive stimulus, whether mechanical, chemical, physical or otherwise.

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

7.8. Who provides substitute consent to Special Treatment?

A Person Responsible cannot provide consent to Special Treatment. Consent to the initial administration of Special Treatment may only be granted by the Guardianship Division of NCAT.

NCAT can only consent to the carrying out of Special Treatment if it is satisfied that the treatment is necessary:

- (a) to save the patient's life, or
- (b) to prevent serious damage to the patient's health.

If the Guardianship Division gives consent to Special Treatment, it can then authorise the guardian to give consent to continuing the treatment or to further treatment of a similar nature.

The *Guardianship Regulation* identifies two categories of Special Treatment for which different criteria apply for obtaining consent from the Guardianship Division:

1. any treatment that involves the administration of one or more restricted substances for the purpose of affecting the central nervous system of the patient, but only if the dosage levels, combinations or numbers of restricted substances used, or the duration of the treatment, are outside the accepted mode of treatment for such a patient
2. any treatment that involves the use of androgen-reducing medication for the purpose of behavioural control.

The NCAT can only consent to the carrying out of these types of treatment if it is satisfied that the treatment is the only or most appropriate way of treating the patient and is manifestly in the best interests of the patient, and in so far as the National Health and Medical Research Council has prescribed guidelines that are relevant to the carrying out of that treatment—those guidelines have been or will be complied with as regards the patient.

Where there is no existing guardianship order in place for a patient, the Health Practitioner should consider making both an application for guardianship and an application for consent to Special Treatment. The Guardianship Division can give consent to Special Treatment for a duration (for example 12 months) so guardianship may not be necessary in some cases, depending on the circumstances of the patient.

Further guidance

- NCAT Guardianship Division Factsheet *Person Responsible*
- NCAT Guardianship Division *Special medical treatment guidelines*

7.9. What if the patient objects to the treatment?

A Person Responsible cannot override a patient's objections to treatment. An objection includes where:

- the person has previously indicated in similar circumstances that he or she did not want the treatment and has not subsequently changed their views, or
- the Person Responsible is aware, or ought reasonably to be aware, that the patient objects to the treatment.

It is an offence under the *Guardianship Act* for treatment to be carried out if the patient is objecting, unless:

- the Guardianship Division of NCAT has consented to the treatment, or
- the Guardianship Division of NCAT has appointed a guardian with express authority to override the patient's objections and the guardian has provided consent, or
- the patient has minimal or no understanding of what the treatment entails, and 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.

An application may also be made to the Supreme Court under its *parens patriae* jurisdiction to consent to necessary treatment where the patient is objecting.

Example

Alison is a 30-year-old woman who requires surgery for gallstones. Although Alison has an intellectual disability, she is usually able to consent to her own medical treatments when they are of a minor nature. Currently, her surgeon has assessed Alison as not having the ability to understand the full details of the proposed treatment. Therefore, her mother has consented to the operation as her Person Responsible under the *Guardianship Act*. However, Alison is refusing to have the operation notwithstanding numerous discussions between Alison, her mother, her social worker and the surgeon.

In view of the nature of the medical treatment and the level of Alison's understanding which would be described as greater than 'minimal or no understanding' the exemption under section 46(4) *Guardianship Act* (outlined above) does not apply. In addition, the treatment is significant and is likely to cause more than transitory distress.

The surgeon cannot rely on the consent of Alison's mother as the Person Responsible while Alison is objecting unless Alison's mother is an appointed guardian with a medical and dental consent authority and an additional authority to override Alison's objections. If the mother has not been formally appointed as a guardian with these functions then in order to obtain lawful consent to the operation, an application must be made to the Guardianship Division of NCAT to consent to the surgery and/or to appoint the mother as a guardian with an on-going medical and dental consent authority and additional authority to override Alison's objections.

7.10. What if the treatment is required in an emergency?

Unless there is a valid ACD, treatment may be provided to a person who is unable to consent where the Medical Practitioner carrying out or supervising the treatment considers treatment is necessary as a matter of urgency to save their life, to prevent serious damage to the patient's health, or (except in the case of Special Treatment), to alleviate significant pain or distress. Consent is not required in these circumstances.

7.11. Treatment administered in the course of a clinical trial

A clinical trial is defined in the *Guardianship Act* as ‘a trial of drugs or techniques that necessarily involves the carrying out of medical or dental treatment on the participants in the 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 Division of the NCAT under the *Guardianship Act*.

In considering an individual patient’s participation in such a trial, the Guardianship Division of NCAT will decide whether consent can be granted by either the Person Responsible or whether it should be granted by the Guardianship Division.

Further guidance

- NSW Civil and Administrative Tribunal, Guardianship Division, *Clinical trials*

8. Minors

8.1. Can I treat a Minor without consent in an emergency?

Yes. Section 174 of the *Children and Young Person's (Care and Protection) Act* allows a Medical Practitioner to carry out medical treatment on a child (15 or under) or young 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 to save their life or to prevent serious damage to their health.

8.2. Can I treat a Minor in an emergency if they or their parents previously objected and refused the treatment?

Section 174 the *Children and Young Person's (Care and Protection) Act* provides a Medical Practitioner with authority to treat a minor in an emergency without consent.

However, where the various treatment options are known well before the treatment becomes urgent, treatment options should be discussed with the Minor and/or the parent(s) before the situation becomes an emergency. This would apply in situations such as where a family has a known objection to blood products and it is known that their child will require heart surgery. Where consensus cannot be reached between the treating team and the family, it may be necessary to obtain a court order to provide guidance as to whether the treatment can proceed before the situation deteriorates into an emergency. Legal advice can be sought from the Ministry of Health's Legal Branch if necessary.

8.3. What is a Mature Minor and when can they consent to non-emergency treatment?

Generally, a Minor is capable of independently consenting to or refusing their medical treatment when they achieve a sufficient level of understanding and intelligence to enable them to understand **fully** what is proposed. This means that there is no set age at which a child or young person is capable of giving consent.

Health Practitioners must decide on a case-by-case basis whether a Minor has sufficient understanding and intelligence to enable them to fully understand what is proposed.

The legal position relating to a Minor's capacity to consent was established by an English case known as *Gillick*. *Gillick* was approved by the High Court of Australia in a case known as *Marion's* case. The *Gillick* case holds that a child's capacity increases as they approach maturity or in other words, the authority of a parent decreases as their child's capacity increases.

The significance of the proposed treatment will be a relevant factor in assessing whether a Minor has capacity to consent. For example, it may be likely that a 15-year-old would be assessed as having the capacity to consent to receive contraceptive treatment, but less likely that she would be assessed as having the capacity to consent to a heart transplant. The child's capacity to consent will need to be assessed carefully in relation to each decision to be made. If a Medical Practitioner assesses a Minor as *Gillick* competent (also known as a Mature Minor) and the Minor can give valid consent, then the consent of the parent or guardian will not be required. However, where the Minor agrees, it is good practice to involve the family in the decision-making process where appropriate.

Where a practitioner assesses a Minor to be a Mature Minor, the *Consent to Medical Treatment (Adults and Mature Minors)* form should be used.

Where a Minor is not considered to be a Mature Minor, the consent of a parent or guardian is required and the *Consent to Medical Treatment (Minors)* form should be used. Depending on the age and understanding of the minor, effort should be made to include the Minor in the decision-making and consent processes.

Pursuant to the *Minors (Property and Contracts) Act 1970*, if a Minor aged 14 and above consents to their own medical treatment the Medical Practitioner may rely on that consent as a defence to a claim against the Medical Practitioner for assault or battery. Also, where medical treatment of a Minor aged less than 16 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. Health Practitioners relying on consent from a Mature Minor aged 13 and under should be especially diligent when assessing the patient’s capacity to consent, as these legal protections will not apply.

Example

Peter is a 14 year old who presents to emergency with a deep laceration to his arm after falling off his bike. The Health Practitioner explains that the cut requires stitches and that this will require a local anaesthetic. Further, that the consequences of not performing the stitches would be possible scarring and infection. The Health Practitioner forms the view, in speaking with Peter, that he fully understands the proposed treatment, and the risks and consequences of not undertaking the treatment, and as such deems him to be a Mature Minor able to consent to his own treatment. When time allows and with Peter’s consent, the Health Practitioner calls Peter’s mother to confirm the consent.

The following is suggested as a **general guide** only and will not apply to all Minors in all circumstances. When considering the table below, Health Practitioners should be aware that when applied, the doctrine of *Gillick* competence or the Mature Minor may necessitate variations to these recommendations.

Table 1: Maturity Guide for Minor’s Capacity to Consent to Medical Treatment

Level of maturity & understanding	Recommendation for Obtaining Consent
Immature and insufficient understanding (may be 13 and under)	Consent from a parent or guardian must be obtained (Attachment B)
Intermediate understanding (may be 14 and 15)	Consent from the young person may be sufficient. However, the consent of a parent or guardian should also be obtained, unless the young person objects to this (refer discussion above on <i>Gillick</i> Competence) (Attachment A or B, depending on the young person’s capacity)
Mature understanding (may be 16 and 17)	Consent of the young person will be sufficient in most cases (refer discussion above on <i>Gillick</i> Competence) (Attachment A)

Further guidance

- *Gillick v West Norfolk and Wisbech AHA* [1986] AC 112
- *Secretary of the Department of Health and Community Services v JWB and SMB* [1992] HCA 15 (Marion’s case)

8.4. Can a Minor refuse treatment?

A Minor who has capacity to consent to their own treatment may also refuse treatment.

A parent or guardian may also refuse treatment on behalf of a Minor who does not have capacity provided such refusal is in the best interests of the child.

However, a court can potentially override a decision of a Minor with capacity, or the decision of a parent or guardian, to avoid serious consequences for the Minor. In this situation, the court would consider the Minor’s age and maturity, and make a decision in the Minor’s best interests.

There is no State Form to document the refusal of treatment by or on behalf of a Minor. Where a Minor with capacity, or the parent/guardian of a Minor, refuses treatment, the procedure below should be followed and documented in the Health Record.

8.5. Non-emergency treatment in case of refusal of consent or conflict between the parent and the Minor

The following is the suggested procedure to follow where clinically indicated treatment is not emergency treatment and consent is refused by either the parents of a Minor, or Minor with capacity or there is conflict between the parent(s) and the Minor:

- Establish that there is no suitable alternative treatment available to which consent would be forthcoming.
- If there is doubt about the Minor's capacity to consent or refuse in their own right, consider obtaining a specialist opinion on capacity.
- Where there is a dispute about the appropriateness of the treatment plan, obtain a second medical opinion and discuss this with the parent(s) or guardian and/or patient.
- Attempt to reach agreement by counselling and repeat discussion with the family. These efforts should be documented.
- 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 the delay would affect the patient.
- In circumstances where the parents do not consent to treatment on behalf of their child, consider whether the refusal of treatment means that there are reasonable grounds to suspect that the Minor is 'at risk of significant harm' to the degree that a report must be made pursuant to the mandatory reporting requirement under section 27, *Children and Young Persons (Care and Protection) Act 1998*. When a report is made to the Child Protection Helpline or the Child Wellbeing Unit because the parent or guardian(s) have refused to consent to treatment, parents should generally be told before the report is made that the Health Service intends to notify the Department of Communities and Justice, unless doing so would place the child or any other person at risk. Making a suspected risk of significant harm report to the Department of Communities and Justice may ultimately lead to a guardian being appointed to consent to the treatment in place of the parents.
- As a last resort, a court order may be sought authorising the treatment. In such cases, support may also need to be given to the family to assist them to obtain legal advice. The matter should be escalated within the Health Service and advice can be sought from the Ministry of Health Legal Branch.
- All discussions and statements and wishes about treatment should be documented in the Minor's Health Care Record.

Example

Sarah is a 17-year-old patient who has Hodgkin's disease and is about to start her third round of chemotherapy following a relapse of the disease. Sarah and her family are followers of the Jehovah's Witness faith and object to having a blood or platelet transfusion. Sarah and her parents have provided a written, signed document to her Medical Practitioner refusing blood or platelet transfusions. Sarah's Medical Practitioner has over 20 years' experience with patients in similar situations and has advised that Sarah will die without chemotherapy treatment. Sarah has a 70% chance of being cured of the disease with chemotherapy treatment, but this treatment will necessitate a blood transfusion, without which Sarah is likely to die from anaemia.

Sarah and her parents seek to have the chemotherapy treatment but refuse to consent to a blood or blood product transfusion. Sarah has been assessed by expert Medical Practitioners as a Mature Minor. She is fully supported by her parents in her decision.

As Sarah is a minor, her refusal of treatment may potentially be overridden by her parents or the court, notwithstanding the fact she is both intelligent and mature. However, before approaching the court, the Medical Practitioner should consider following the procedures set out in this Consent Manual and:

- (a) consider any alternative appropriate treatment for which consent would be forthcoming
- (b) consider obtaining a second opinion from a suitably qualified Medical Practitioner to confirm the prognosis and treatment plan
- (c) attempt to reach agreement with Sarah and her family by repeat discussions and counselling
- (d) if no agreement can be reached, consider whether the refusal of treatment means that there are reasonable grounds to suspect that Sarah is 'at risk of significant harm' to the degree that a suspected risk of significant harm report must be made to the Department of Communities and Justice pursuant to the mandatory reporting requirement under section 27, *Children and Young Persons (Care and Protection) Act 1998*.

Finally, the Medical Practitioner should escalate the issue within the Health Service and urgently seek advice from Ministry of Health Legal Branch to obtain an appropriate court order for guidance on a treatment plan. In this situation, the court may invoke its *parens patriae* jurisdiction to make an order based on the best interests of Sarah. In making its decision the court is likely to take into account the nature of the disease, the nature of the treatment, the reasons for the treatment, the desirability of the treatment, the risks to Sarah's health with and without the proposed blood transfusions, the faith and views of Sarah and her parents, and the views of the attending Medical Practitioners.

8.6. When can a Minor consent to sexual health treatment?

As for all medical treatments, to provide sexual health treatment, a Health Practitioner must be satisfied that the Minor has sufficient understanding and intelligence to enable them to fully understand what is proposed, taking into account the significance of the treatment. The Health Practitioner should document in the Health Record the assessment of the Minor as having sufficient understanding and intelligence to consent to sexual health treatment.

It is generally established that a Mature Minor may consent to the prescription of hormonal contraception (including the oral contraceptive pill, injectable and implantable hormones and long-term reversible contraception including intrauterine devices) and treatment for sexually transmitted infections provided the Health Practitioner assesses the patient as having capacity to give informed consent. Such assessments must be made on a case-by-case basis and are dependent on professional judgement.

In circumstances where a Health Practitioner decides that a Minor seeking sexual health treatment is not sufficiently mature to consent to the treatment, the Health Practitioner should talk to the minor indicating there is a need for parental or guardian involvement in the consent process and discuss consent options with the minor.

Health Practitioners who have reasonable grounds to suspect that a child is at risk of significant harm (for example, where it is apparent that the patient's sexual partner(s) is/are more than two years older than the patient) are required to make a report to the Department of Communities and Justice pursuant to the mandatory reporting provisions of the *Children and Young Persons (Care and Protection) Act 1998*. However, the making of such a report does not preclude the Mature Minor from consenting to the medical treatment nor does it preclude that treatment being provided.

8.7. Who is able to consent on behalf of a Minor if their parents have separated?

The consent of either parent to their child's medical treatment is usually enough, as the law makes it clear that each parent has full responsibility for each of their children who are under 18 and parental responsibility is not affected by changes to relationships (that is, if the parents separate or are divorced).

There are two circumstances where the consent of either parent may not be enough:

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

The court can make a number of different types of parenting orders which may set out matters such as who the child will live with, how much time they will spend with the other parent or the allocation of parental responsibility.

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

Health Services may develop local level policies and procedures for establishing the existence or otherwise of court orders where the parents of a Minor have separated. Legal advice from Ministry of Health Legal Branch can be sought if there is uncertainty.

8.8. 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 more often in certain cultures, for example, in relation to Aboriginal children, where an extended family member, rather than the child's mother or father, might be responsible for giving consent on their behalf.

Ideally, this delegation would be in writing. If a written delegation exists, a copy of it should be placed on the Minor's Health Record. If the delegation was given verbally, it should be confirmed with the parent or guardian and documented in the Minor's Health Record.

If a Minor presents with an adult other than a parent, the Health Practitioner 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 (that is, a previous objection by the parent to that person exercising any authority in relation to the child). This does not apply to children in statutory out-of-home care or detention who have an appointed authorised carer (see below).

8.9. What if the Minor is in out-of-home care or in detention?

Children in statutory out-of-home care or detention are in the parental responsibility of the Minister for Families, Communities and Disability Services and day-to-day care responsibility lies with the authorised carer. The term 'authorised carer' is defined in section 137 of the *Children and Young Persons (Care and Protection) Act 1998*.

The authorised carer has authority under the *Children and Young Persons (Care and Protection) Act 1998* to consent to medical treatment not involving surgery on the advice of a Medical Practitioner. This ensures that children and young people in out-of-home care can receive appropriate and timely day to day medical and dental treatments. The authorised carer is not able to delegate their responsibility for consenting to medical treatment to another adult.

Minors detained in a detention centre can be treated in the absence of consent in certain circumstances under section 27 of the *Children (Detention Centres) Act 1987*.

Further guidance

- NSW Health Guidelines *Health Assessment of Children and Young People in Out-of-Home Care (Clinical Practice Guidelines)* (GL2013_013)
- Department of Communities and Justice Factsheet *Consent for Medical and Dental Treatment of Children and Young Persons in out-of-home care*
- Department of Communities and Justice *Medical and Dental Consent Tool*

8.10. Can a Mature Minor make a valid Advance Care Directive?

Unlike an ACD written by an adult with capacity, an ACD written by a Mature Minor will not necessarily be legally binding. An ACD written by a Mature Minor will be treated in the same way that a Mature Minor's consent or refusal is treated – that is, it may be overridden by parents, or the court, if to do so would be in the best interests of the Minor.

In some circumstances, where a Mature Minor has prepared a written ACD, it may be appropriate to obtain a court order specifying whether the ACD must be followed.

8.11. What are the legal requirements for Special Medical Treatment in relation to children?

The *Children and Young Persons (Care and Protection) Act 1998* classes some procedures as Special Medical Treatment. It is an offence to carry out these procedures/treatments on a child less than 16-years-old unless:

- 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
- the treatment is described in paragraphs (a) or (b) below, and the Guardianship Division of NCAT has consented to the treatment.

The definition of Special Medical Treatment under the *Children and Young Persons (Care and Protection) Act 1998* is different from that which is used under the *Guardianship Act*. The definition of Special Medical Treatment under the *Children and Young Persons (Care and Protection) Act 1998* includes the following:

- (a) any procedure or treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person unless the treatment is intended to remediate a life-threatening condition and from which permanent infertility, or the likelihood of permanent infertility, is an unwanted consequence
- (b) any medical treatment in the nature of a vasectomy or tubal occlusion
- (c) 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 Secretary of the Department of Communities and Justice on the written request of the Secretary of the Ministry of Health
- (d) any medical treatment that involves an experimental procedure that does not conform to the document entitled *National Statement on Ethical Conduct in Human Research 2007* published by the National Health and Medical Research Council in 2007 and updated in 2018.

Further guidance

- Department of Communities and Justice *General Exemption*
- NSW Civil and Administrative Tribunal Guardianship Division *Special Medical Treatment for people under 16 years*

9. Consent for patients being treated under the *Mental Health Act 2007*

9.1. What is the purpose of the *Mental Health Act*?

The *Mental Health Act* provides the legislative framework for the voluntary and involuntary treatment of persons with a mental illness or mental condition in NSW.

The principles for care and treatment of patients under the *Mental Health Act* require Health Practitioners to make every effort to take into account the patient's views and wishes about their treatment, obtain patient consent for treatment and recovery plans and to support patients who lack the capacity to consent to understand those plans.

The Act provides for an authorised medical officer to make a range of decisions about a person detained in a mental health facility.

9.2. Who is an authorised medical officer?

An authorised medical officer of a mental health facility is the medical superintendent of the mental health facility (appointed under section 111 of the Act) or a medical officer, nominated by the medical superintendent who is attached to the mental health facility.

9.3. What is a mental health facility?

Under the *Mental Health Act*, a person assessed as mentally ill or mentally disordered may be taken to a declared mental health facility for assessment. If the person also requires treatment for a non-mental health illness or condition, the person can be detained in a non-mental health facility. Otherwise, the detention of a person in a non-declared mental health facility may be illegal.

The *Mental Health Act* allows the Secretary of the Ministry of Health to declare any facility to be a declared mental health facility. There are currently three classes of declared mental health facility; mental health emergency assessment class, mental health assessment and inpatient treatment class and community or health care agency class.

Further guidance

- NSW Health website - [Declared mental health facilities](#)

9.4. What are the categories of patients under the *Mental Health Act* relevant to obtaining consent?

There are six distinct categories of patients who may be treated in a mental health facility under the mental health legislation (including the *Mental Health Act* and the *Mental Health (Forensic Provisions) Act 1990 (NSW)*):

1. *Voluntary patients*: patients who have voluntarily been admitted to a mental health facility.
2. *Mentally disordered persons*: patients who are detained for short periods of time, as their behaviour is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary.
3. *Assessable persons*: persons who are detained in a facility under the Act but who have not yet been the subject of a mental health inquiry conducted by the Mental Health Review Tribunal (MHRT)
4. *Involuntary patients*: patients who have been ordered to be detained following a mental health inquiry conducted by the MHRT. Involuntary patients also include forensic and correctional patients who have been re-classified by the MHRT as an involuntary patient.
5. *Forensic patients*: Under the *Mental Health (Forensic Provisions) Act*, a forensic patient is a person who:
 - is found not guilty of a criminal offence due to mental illness, or
 - is ordered to be detained and they are unfit to be tried before a criminal court, and/or
 - is subject to a limiting term in respect of an offence (a limiting term is the best estimate of what the court would have imposed if the person had been subject to a standard criminal trial in respect of an offence); and/or
 - is subject to an extension order under a limiting term.

A forensic patient may or may not have a current mental illness or cognitive impairment. Whether or not the forensic patient has a mental illness impacts on who can provide substitute consent to surgical treatment and in what circumstances.

6. *Correctional patients*: persons who are inmates in a correctional facility who are transferred to a mental health facility on order of the Health Secretary under section 55 of the *Mental Health (Forensic Provisions) Act* in order to receive mental health treatment. A correctional patient may not necessarily have a mental illness. Whether or not the correctional patient has a mental illness impacts on who can provide substitute consent to surgical treatment and in what circumstances.

9.5. When do the provisions of the *Mental Health Act* apply for obtaining consent for medical treatment?

The *Mental Health Act* consent provisions apply to both voluntary and involuntary detained patients and cover both mental health treatment and other more general medical and dental treatment, including surgery. In relation to forensic patients, the *Mental Health (Forensic Provisions) Act* also stipulates that the Mental Health Review Tribunal has powers to make orders for a forensic patient's care and treatment.

Where a patient is detained in a mental health facility under the *Mental Health Act* the authorised medical officer of the mental health facility can authorise the giving of any non-surgical treatment (including any medication) the officer deems fit.

While an authorised medical officer can authorise the giving of medical treatment to a detained patient, all reasonable attempts should be made to obtain the consent of the patient. However, certain types of treatment require additional consent processes, such as surgical treatment and electro-convulsive therapy (ECT).

Where a patient is a voluntary mental health patient, the patient's consent must be obtained for any treatment. If the patient lacks capacity, consent can be given in accordance with the *Guardianship Act*. This is the case even where the patient is in a declared mental health facility – the Person Responsible can give consent for most mental health and non-mental health related medical treatment where the person lacks capacity. However, certain types of treatment such as ECT, require additional consent processes.

Further guidance

- *Mental Health Act (2007) Guidebook*

9.6. What is the process for obtaining consent for voluntary patients with capacity?

In accordance with the general law of consent, if a patient is a voluntary mental health patient, the patient's consent is required before any mental health treatment or general medical and dental treatment is provided.

9.7. What is the process for obtaining consent for voluntary patients without capacity?

When a voluntary patient lacks the capacity to consent (due to mental illness or otherwise), to medical, surgical or dental treatment the substitute consent provisions of the *Guardianship Act* will apply (see section 7.7). However, ECT can only be given with the voluntary patient's consent.

9.8. What is the process for obtaining consent to medical treatment for assessable patients?

An authorised medical officer can authorise the giving of any treatment (including medication) to a person detained in a mental health facility, including an assessable person, under section 84 of the *Mental Health Act*. However, all reasonable efforts should be made to obtain the patient's consent.

However, the other provisions of the *Mental Health Act* relating to surgical treatment (including Special Medical Treatment), do not apply to assessable persons. As such, if an assessable person requires surgery and lacks the capacity to consent, consent must be obtained in accordance with the *Guardianship Act*.

9.9. What is the process for obtaining consent to medical treatment for involuntary patients (including forensic patients and correctional patients who suffer from a mental illness)?

The process for obtaining consent for involuntary patients varies depending on whether they have capacity to consent and the category of treatment concerned being either:

- general medical and dental treatment (non-surgical);
- surgical treatment (emergency or non-emergency);
- ECT and Special Medical Treatment.

9.9.1. Medical treatment

Where a patient is detained under the *Mental Health Act* section 84 allows the authorised medical officer of the mental health facility to authorise the giving of any non-surgical treatment (including any medication) the officer thinks fit. However, all reasonable efforts should be made to obtain the patient's consent.

9.9.2. Surgical treatment

It is important to note that the surgical provisions under Chapter 4 Part 3 of the *Mental Health Act* apply to both involuntary patients (including forensic and correctional patients who have a mental illness) who have the capacity to consent to treatment as well those that do not have capacity. These provisions apply to all surgical treatment except Special Medical Treatment within the meaning of the *Mental Health Act*.

Emergency surgery

An authorised medical officer under the *Mental Health Act* or the Secretary of Ministry of Health (or delegate) may consent to emergency surgery on behalf of an involuntary patient, if, in the authorised medical officer's or Secretary'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 damage to the health of the patient or to prevent the patient from suffering or continuing to suffer significant pain or distress.

Any such consent should be in writing and signed. The authorised medical officer must notify the MHRT and the patients' Designated Carer and Principal Care Provider of the emergency surgery as soon as practicable after becoming aware of the performance of the emergency surgery.

Non-emergency surgery

Prior to lodging an application for non-emergency surgery, the authorised medical officer must provide 14 days (timeframe may be reduced if there is some urgency) notice to an involuntary patient's Designated Carer and Principal Care Provider (if the Principal Care Provider is not the Designated Carer) of the intention to seek consent for the surgery. The response of the Designated Carer or Principal Care Provider, as well as the provision of consent by the patient, determines whether the application will be to the MHRT or the Secretary.

Non-emergency surgery – Consent by Secretary of Ministry of Health (or delegate)

The authorised medical officer can only apply to the Secretary for consent if the patient's Designated Carer has agreed to this in writing, otherwise, the application must be made to the MHRT. The Secretary may only consent to the performance of the surgical operation if they are of the opinion that:

- the patient is incapable of giving consent to the operation, and
- it is desirable, having regard to the interests of the patient, to perform the surgical operation on the patient.

The Secretary of the Ministry of Health cannot consent to surgery on an involuntary patient, where the patient has capacity but has not provided consent to the operation. In such a case, consent must be sought from the MHRT.

Non-emergency surgery – Consent by the Mental Health Review Tribunal

The authorised medical officer *must* apply to the MHRT for consent to the performance of a surgical operation on an involuntary patient if:

- none of the patient's Designated Carers have consented to the surgical operation, and/or
- the patient has capacity but refuses to consent.

The MHRT can only consent to the surgery if they consider that the patient is:

- incapable of giving consent, or
- is capable of giving consent but refuses to give that consent, or
- neither gives nor refuses to give that consent

AND

- it is desirable, having regard to the interests of the patient, to perform the surgical operation on the patient.

9.10. Who provides consent to treatment for a forensic or correctional patient not suffering from a mental illness?

General medical and dental treatment (non-surgical)

All reasonable efforts should be made to obtain the patient's consent to general medical and dental treatment. In addition, the authorised medical officer may authorise the giving of, any non-surgical treatment (including any medication) the officer thinks fit.

Emergency and non-emergency surgery

The requirements for surgical treatment of a forensic or correctional patient who is not suffering from a mental illness are the same as with involuntary patients requiring surgery (see 9.11 above) except with respect to the requirements concerning the patient's capacity.

For forensic and correctional patients without a mental illness, consent to surgery (emergency or non-emergency) may only be granted where, in the opinion of the authorised medical officer or Secretary (emergency surgery) or the MHRT (non-emergency surgery), the patient is incapable of consenting.

Further guidance

- [Mental Health Review Tribunal Civil Hearing Kit](#) (Section 7)

9.11. Electro-convulsive therapy

9.11.1. Who can administer electro-convulsive therapy (ECT)?

ECT may only be administered by a Medical Practitioner at a mental health facility or other place approved by the Secretary of Health in accordance with the *Mental Health Act*.

9.11.2. Is a patient able to consent to ECT themselves?

A patient may consent to ECT themselves if:

- they are a voluntary patient, and
- they are 16 years or over, and
- they are capable of giving informed consent in accordance with the requirements set out under section 91 of the *Mental Health Act*.

If the patient satisfies the above criteria then ECT can only be administered if in addition, at least two Medical Practitioners, at least one of whom is a psychiatrist, complete a certificate (See *Mental Health Regulation 2019*, [Schedule 1 Form 5 Information and Consent – Electro Convulsive Therapy](#)) to certify that they have:

- considered the clinical condition of the patient, the history of treatment and any appropriate alternatives, and
- certified in writing that in the opinion of the Medical Practitioner ECT is a reasonable and proper treatment to be administered to the patient and is necessary or desirable for their safety or welfare.

9.11.3. What if the authorised medical officer is not sure whether the patient has the capacity to give informed consent to ECT?

If capacity of the voluntary patient is uncertain, an application may be made to the MHRT for an ECT Consent Inquiry pursuant to section 93(3) to determine whether the patient is capable of giving consent and has given that consent. If a voluntary patient lacks capacity, no substituted decision maker can consent on their behalf.

9.11.4. What are the requirements for informed consent for ECT under section 91 of the *Mental Health Act*?

A person is taken to have given informed consent to the administration of ECT if the person gives a free, voluntary and written consent after information is provided in accordance with the requirements of section 91 as follows:

- (a) a fair explanation must be made to the person of the techniques or procedures to be followed, including identification and explanation of any technique or procedure about which there is not enough data to recommend it as recognised treatment or to reliably predict the outcome of its performance
- (b) a full description must be given, without exaggeration or concealment, to the person of any possible discomforts and risks of the treatment (including possible loss of memory)
- (c) a full description must be given to the person of any expected benefits of the treatment,

- (d) a full disclosure must be made, without exaggeration or concealment, to the person of any appropriate alternative treatments that would be advantageous to the person
- (e) an offer must be made to the person to answer any inquiries concerning the procedures or any part of them
- (f) the person must be given notice that the person is free to refuse or to withdraw consent and to discontinue the procedures or any part of them at any time
- (g) a full disclosure must be made to the person of any financial relationship between the person proposing the administration of the treatment or the administering Medical Practitioner, or both, and the facility in which it is proposed to administer the treatment
- (h) the person must be given notice of their right to obtain legal and medical advice and to be represented before giving consent
- (i) any question relating to the techniques or procedures to be followed that is asked by the person must have been answered and the answers must appear to have been understood by the person
- (j) a form setting out the steps in this subsection is to be given to the person and an oral explanation of the matters dealt with in the form is to be given to the person in a language with which the person is familiar.

Further guidance

- [Schedule 1 Form 5 - Information and Consent - Electro-Convulsive Therapy](#)
- [NSW Health Mental Health Review Tribunal](#)

9.11.5. Who may consent to ECT on behalf of involuntary patients or patients under 16 years of age?

ECT treatment cannot be given to involuntary patients (including forensic patients, correctional patients and any persons detained in a mental health facility) or persons under 16 without the approval of the MHRT.

An application to the MHRT may be made by the authorised medical officer for an *ECT Administration Inquiry* along with a certificate by two Medical Practitioners, at least one of whom is a psychiatrist. If the patient is under 16-years-old at least one of the medical certificates must be from a psychiatrist with expertise in the treatment of children or adolescents.

The authorised medical officer must do everything reasonably practicable to give notice in writing to the Designated Carer(s) and the Principal Care Provider of the person.

Further guidance

- [NSW Health Mental Health Review Tribunal](#)

9.12. Special Medical Treatment - *Mental Health Act*

9.12.1. What is Special Medical Treatment under the *Mental Health Act*?

Special Medical Treatment is any treatment, procedure, operation or examination that is intended, or is reasonably likely, to have the effect of rendering a patient permanently infertile.

9.12.2. Can Special Medical Treatment be provided to a patient in an emergency?

Special Medical Treatment may only be provided to a patient (voluntary or involuntary) who is 16 years or over in an emergency where:

- the person carrying out the treatment is a Medical Practitioner, and
- the Medical Practitioner providing the treatment is of the opinion that the Special Medical Treatment is necessary, as a matter of urgency, in order to save the patient's life, or prevent serious damage to the patient's health.

9.12.3. When can the Mental Health Review Tribunal consent to Special Medical Treatment on an involuntary patient (including a forensic or correctional patient)?

If Special Medical Treatment is recommended for an involuntary patient (16 years or over) an authorised medical officer may apply to the MHRT for consent.

The MHRT may only consent to the carrying out of Special Medical Treatment (other than prescribed Special Medical Treatment) on a patient if:

- the patient is over the age of 16 years, and
- the MHRT is satisfied that the Special Medical Treatment is necessary to prevent serious damage to the health of the patient.

Special considerations apply to applications for prescribed Special Medical Treatment (see section 103(3) *Mental Health Act*).

Before lodging an application with the MHRT, an authorised medical officer must provide 14 days' notice of the proposed treatment to the patient's Designated Carer(s) and the Principal Care Provider unless the authorised medical officer is of the opinion that the urgency of the circumstances requires an earlier determination, or the person notified does not object.

Further guidance

- Mental Health Review Tribunal, *Civil Hearing Kit Surgery or Medical Treatment*

10. Consent for specific treatment/procedures

10.1. Blood transfusions

The administration of a blood transfusion or the administration of blood products requires written consent. Blood products include 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.

Consent for a blood transfusion or the administration of blood products must be obtained by the Admitting Medical Officer or a Health Practitioner to whom the task is properly delegated. In most cases, it should be obtained by a Medical Practitioner.

These requirements may not be practical in small rural hospitals where there are no resident medical staff to provide the information to the patient and obtain a completed consent form. There are also circumstances where it is appropriate for Nurses or Midwives to administer standardised therapeutic interventions (for example routine administration of Anti-D). Health Services may develop local policies to address these situations. In developing such policies, Health Services should have regard to the following:

- 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 Health Practitioner who is fully informed of the clinical circumstances of the patient.
- Health Services should provide, where necessary, additional training to appropriately skilled Nurses or Midwives so that they can provide clinically relevant and accurate information. The need for additional training as circumstances change should be considered.
- 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.

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 in emergency situations where the patient is unable to give a valid consent.

A refusal of blood products should be documented in the patient's Health Records.

10.2. Information and Consent requirements for pregnancy and birth related tests, procedures and interventions

Early discussions with respect to the range of pregnancy and birth related tests, procedures and interventions ensure women have adequate information and time to consider their options, express preferences, make choices and where necessary give valid consent. During the antenatal period, the Health Practitioner should provide prepared information to support these discussions (for example, the NSW Health *Having a Baby* book) and the woman's preference should be recorded in her Health Record (noting that preferences may change over time).

The principles informing these discussions should focus on shared decision making, informed consent and respecting the choices of the woman. The relative merits, material risks, implications for mother and baby, the timing of these interventions and any potential alternatives to the interventions should be discussed and documented in the Health Record.

10.2.1. Antenatal testing and screening

Written consent is not required for routine antenatal testing and screening (including ultrasound scans, blood tests and CTGs) and choices about models of care. Verbal consent (or informed refusal) should be recorded in the Health Record.

10.2.2. Planned pregnancy, labour and birth related procedures and interventions

If consent to a particular pregnancy or birth related procedure is given in the antenatal period or where the consent is obtained in the obstetrician's private rooms, this consent should be confirmed on the day of the procedure and the woman given an additional opportunity to ask questions about the procedure/intervention. This confirmed consent must be documented in the Health Record.

Written consent is required for all planned pregnancy, labour and birth related procedures and interventions (as opposed to unplanned or emergency – see below) using the *Consent to Medical Treatment/Procedure (Adult with Capacity)* Form.

This may include procedures including but not limited to elective caesarean section, vaginal birth after caesarean, induction of labour, planned vaginal twin birth, planned vaginal breech birth or external cephalic version (ECV) and termination of pregnancy.

Written consent is not required for a spontaneous vaginal birth.

10.2.3. Unplanned labour and birth-related procedures and interventions

For unplanned labour and birth-related procedures and interventions, where practicable in the circumstances and where time allows, the woman's written consent should be recorded using the *Consent to Medical Treatment/Procedure (Adult with Capacity)* Form. Examples include insertion of an epidural block or an instrumental birth. If a procedure or intervention is required in an emergency to save a life, written consent is not required, however, the woman's oral or implied consent should be recorded in the Health Record.

Written consent is not required for perineal repair under local anaesthetic performed in a birth unit.

10.2.4. Refusal of recommended treatment in a maternity setting

This Consent Manual refers to choosing to decline treatments as refusal of treatment, as this is how these cases are described in a legal context.

There may be circumstances where a woman refuses care and/or advice which would amount to a departure from the Health Service or NSW Health policy or guidelines, for example, declining screening tests, continuous fetal heart rate monitoring, caesarean section or induction of labour. There are various reasons why a woman may refuse recommended medical treatment including social, religious or personal views and, in some cases, a fear of medical treatment.

The law is that unless the woman lacks capacity, the woman's right to refuse medical treatment prevails over preservation of a potential life. Where time allows, advice may be obtained from the Ministry of Health, Legal Branch if there is a dispute or concern about the woman's capacity. Although it may not always be possible, the early identification of women who wish to decline specific interventions will assist with early multi-disciplinary collaboration and planning.

Refusal of treatment may result in a conflict between the woman's wishes and the recommendations of the treating Health Practitioner. Such refusal of treatment may, in some circumstances, be considered to pose a serious risk to the welfare of the fetus or the woman. In these circumstances the Health Practitioner should clearly advise the woman of the risks of refusing the treatment and, where possible, obtain written acknowledgement of the provision of information by the Health Practitioner of the risks and the refusal of the recommended treatment. The *Procedure/Treatment Refusal Acknowledgement (Patient with Capacity)* form can be used for this purpose.

There may be circumstances where the refusal of treatment in this context provides grounds to suspect that the baby may be at risk of significant harm after birth. In these cases, a prenatal report may be made to the Child Protection Helpline or assistance sought from the NSW Health Child Wellbeing Unit.

10.2.5. Refusal of recommended treatment in a maternity setting – Local Level Policy

Health Services must implement a local level policy to support women and staff when a woman is declining recommended medical treatment.

The local level policy must:

- emphasise a collaborative approach to maternity care. Allow the woman an opportunity for informed refusal whereby she is provided with information regarding the benefits of treatment from her Health Practitioner so that she can make a decision that reflects self-determination, autonomy and control.
- clearly state the current law in NSW. A competent adult is free to choose whether they will consent to medical care. A court is unlikely to qualify a pregnant woman's right to refuse treatment even if her decision might pose a serious threat to her welfare or to that of the fetus, unless the capacity of the mother is in question.
- require a capacity assessment. Where a woman is refusing recommended medical treatment and the refusal of treatment could lead to serious risks to her welfare or the fetus, the Health Practitioner must consider whether there is any reason to consider that a woman's capacity may be reduced to the point that she is unable to understand the nature and consequences of the decision she is making. If there is a question regarding the woman's capacity, a capacity assessment should be conducted. Where time allows, advice should be obtained from the Ministry of Health, Legal Branch.
- emphasise open and continuing communication with the woman. It is important that good communication with the woman is maintained by providing unbiased and accurate information regarding the options available and the consequences of each. Utilise techniques to build agreement on the recommended treatment which may include:
 - time and repeated discussion
 - second medical opinion
 - involvement of a neutral third party
 - transfer to the care of another Health Practitioner.

Acknowledgement and understanding of cultural sensitivities may assist Health Practitioners to reach agreement with the woman regarding recommended medical treatment and, where time allows, the involvement of specialist cultural advisors within NSW Health may be beneficial for example, the Aboriginal liaison team.

- require meticulous record keeping regarding the discussions that have taken place with the woman and Health Practitioners is essential. If the woman maintains her refusal of the recommended treatment, and, subject to the Health Practitioner having made reasonable efforts to reach agreement with the woman by way of a full and frank discussion, the Health Practitioner should complete a *Refusal of Treatment* form. The Health Practitioner must be sure to record the discussions that have taken place with the woman including the proposed treatment, its nature, material risks and the possible consequences of refusing the treatment. Once completed, the woman should be requested to sign the form and the form filed in the woman's Health Record. If the woman chooses not to sign the form, this should be noted on the form and the completed form should be signed by the Health Practitioner and filed in the woman's Health Record.
- include mechanisms for support and debrief of staff involved. In situations where a woman's refusal of recommended medical treatment results in injury or death to a woman or the fetus, all staff involved should be provided with appropriate support and an opportunity to debrief following the incident.

Further guidance

- NSW Health Policy Directive *Maternity – National Midwifery Guidelines for Consultation and Referrals* (PD2010_022)
- NSW Health Policy Directive *Framework for Termination of Pregnancy in NSW* (PD2019_048)

10.3. Anaesthetics

Patients must be informed about the material risks associated with anaesthesia for their planned procedure. This information may be provided by the Admitting Medical Officer, or in some cases (such as for regional anaesthesia) a Nurse Practitioner. However, if the Admitting Medical Officer considers the anaesthesia to involve particularly high risks or there are other circumstances in a particular case that warrant a separate consultation, the Admitting Medical Officer should arrange a separate consultation with the anaesthetist.

Where there is a separate consultation with the anaesthetist, the patient should be asked to sign a separate consent form in relation to the anaesthetic.

If alternative types of anaesthetic, for example, regional or general are commonly used for the procedure, these must be discussed together with their advantages and disadvantages and these discussions should be documented.

10.4. Organ and tissue donation

Consent requirements for organ and tissue donation are addressed in the *Human Tissue Act* and the *Human Tissue Regulation*. Specific consent forms are provided under that Act.

Further guidance

- NSW Health Policy Directive *Deceased Organ and Tissue Donation – Consent and other Procedural Requirements* (PD2013_001)

10.5. Consent to use tissue removed from a living patient during treatment

Consent requirements for the use of any tissue removed during medical, surgical or dental treatment for any medical, therapeutic or scientific purposes, other than the on-going treatment of the patient are addressed in the *Human Tissue Act* and the *Human Tissue Regulation*.

Further guidance

- NSW Health Policy Directive *Donation, Use and Retention of Tissue from Living Persons* (PD2016_001)

10.6. Research (including clinical trials)

Research conducted on humans at Health Services requires the approval of a registered Human Research and Ethics Committee (HREC) following the principles set out in the *National Statement on Ethical Conduct in Human Research* (National Statement).

The HREC's role is to review and approve specific consent protocols for all operations, procedures and treatments that are part of clinical trials or studies. As a general rule, the same legal principles apply when seeking a patient's consent for clinical trials or research as for medical treatment or procedures. Researchers should ensure they follow any specific consent requirements, including the provision of patient information sheets, which have been approved by the reviewing HREC in accordance with the National Statement. Generally, written consent will be required where research involves any type of operations, procedures or treatments but may not be necessary in every situation, for example, research involving surveys may not always require written consent but can be implied through the completion of the survey.

Further guidance

- NSW Health Guidelines *Human Research Ethics Committees – Standardised Patient Information Sheets (PIS)* (GL2007_016)
- NSW Health Guidelines *Human Tissue – Requirements of the Human Tissue Act 1983 in relation to research & use of tissue* (GL2006_021)
- National Health and Medical Research Council *National Statement on Ethical Conduct in Human Research 2018*
- Therapeutic Goods Administration *Integrated Addendum to ICH E6(R1): Guideline for Good Clinical Practice ICH E6 (R2)*
- NSW Health Policy Directive *Research – Ethical and Scientific Review of Human Research in NSW Public Health Organisations* (PD2010_55).

10.6.1. Consent for children participating in research or clinical trials

Whilst an HREC may occasionally allow for patients between the ages of 16 and 18 to provide consent to their own participation in a clinical trial or medical research, it is generally recommended that a parent/guardian consent to participation in clinical trials or research for children up to the age of 18.

Chapter 4.2 of the National Statement provides guidelines with regard to the values, principles and themes to be applied when obtaining consent in regard to research involving children. In addition to obtaining substitute consent of the parents or guardians, researchers should consider, where appropriate to the child's maturity, obtaining the assent or agreement of the child to participate in the clinical trial or research. Obtaining the assent of a child is in accordance with accepted ethical standards in research in Australia. Ultimately, the HREC should make the determination as to whether assent should be obtained from a child participant, taking into account the provisions of the National Statement and the specifics of the relevant study. However, this is recommended only when the child is considered to have sufficient maturity to be able to understand the clinical trial or research process and is able to express a view on whether they would like to be a participant.

Both the consent and assent processes require that children understand the research process and are informed about their involvement. Information should be provided to children in a way that they understand, and they should be provided with the opportunity to seek further information and receive satisfactory answers. Where a child's participation in a research project is on-going, researchers should obtain consent from the patient in their own capacity once they obtain the age of 18 years.

Further guidance

- [National Health and Medical Research Council National Statement on Ethical Conduct in Human Research 2007 - updated 2018](#)

10.6.2. Consent for persons 16 years or above without capacity participating in research or clinical trials

Special arrangements apply where a person is 16 years of age or above and is unable to consent to participate in clinical trials and research. Under part 5 of the *Guardianship Act 1987*, clinical trials which seek to involve persons 16 years of age or older without capacity must be approved by the Guardianship Division of NCAT. The purpose of the provisions is to ensure that people who lack the capacity to consent are not deprived of medical treatment that is only available through a clinical trial and to ensure that they are only provided with treatment that promotes their health and wellbeing.

Further guidance

- Section 7 - Patients (16 years or over) who do not have capacity to consent
- [NSW Civil and Administrative Tribunal, Guardianship Division Clinical Trials](#)
- NSW Health Guidelines *Human Tissue - Requirements of the Human tissue Act 1983 in relation to research and use of tissue* (GL2006_021)

10.7. Procedures that may impact on people other than the patient

Some procedures, such as 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 be possible to obtain the patient's written consent to disclose results to an identifiable third party at this early stage.

Since 2014, the *Health Records and Information Privacy Act 2002* has included provisions and processes for the disclosure of genetic information to genetic relatives without patient consent in limited circumstances. Genetic relative means a person who is related to an individual by blood, for example, a sibling, parent or descendant of the individual.

Under the amended Health Privacy Principles 10 and 11, genetic information can be used and disclosed where:

- the disclosure is to a genetic relative of the individual to whom the genetic information relates
- it is reasonably believed to be necessary to lessen or prevent a serious threat to the life, health or safety (whether or not the threat is imminent) of that genetic relative
- the disclosure is made in accordance with guidelines, if any, issued by the NSW Privacy Commissioner for the purposes of this paragraph.

The NSW Privacy Commissioner has issued guidelines *Use and disclosure of genetic information to a patient's genetic relatives*. The guidelines recommend that Medical Practitioners take all reasonable steps to obtain consent from the patient and to consult with other experienced Health Practitioners. If a disclosure occurs, only information that is necessary to communicate the risk of harm should be disclosed and, where possible, the patient should be notified.

Further guidance

- NSW Information and Privacy Commission *NSW Genetic Health Guidelines: Use and disclosure of genetic information to a patient's genetic relatives: Guidelines for organisations in NSW*
- NSW Health *Privacy Manual for Health Information*, section 11.2.3.4, Genetic Information

10.8. Medical and Forensic examinations

A medical and forensic examination is an examination which includes injury documentation and the collection of forensic samples which can be used as evidence in a police investigation and any subsequent prosecution. A medical and forensic examination occurs in the context of an integrated psychosocial, medical and forensic response to a victim of criminal violence, abuse or neglect. A medical and forensic examination may be conducted by a registered Medical Practitioner or, in relation to the sexual assault of people 14 years and over, a specially trained Sexual Assault Nurse Examiner (SANE).

The principal focus of a medical and forensic examination is the care and treatment of the patient and the secondary focus is the collection of evidence to be used for an investigation or criminal prosecution.

Medical and forensic examinations require careful adherence to consent procedures. Written consent must be obtained before a medical and forensic examination is provided. Further detail on the consent requirements are set out in the documents below.

The patient will be asked to consent to the examination, and separately consent to release information obtained in the examination to the NSW Police Force. A patient may consent at a later time to the release of information to the NSW Police Force.

Further guidance:

- NSW Health Policy Directive *Sexual Assault Services Policy and Procedure Manual (Adult)* (PD2005_607), section 9 'Medical Assessment and Management'
- NSW Health Policy Directive *Clinical Practices – Adult Sexual Assault Forensic Examinations Conducted by Nurse Examiners* (PD2005_614)
- NSW Health Policy Directive *Photo and Video Imaging in Cases of Suspected Child Sexual Abuse, Physical Abuse and Neglect* (PD2015_047)
- NSW Health Policy Directive *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* (PD2013_007)
- NSW Health Guideline *Suspected Child Abuse and Neglect (SCAN) Medical Protocol* (GL2014_012)
- Department of Communities and Justice *Preventing and responding to abuse of older people (Elder Abuse) NSW Interagency Policy*
- NSW Civil and Administrative Tribunal out of hours Guardianship Applications 1300 006 228.

10.9.Restrictive practices

In general, a competent adult patient has the right to consent to, or refuse, any treatment, including seclusion or restraint. As a result, where possible, seclusion and restraint should only be used with the informed consent of the person.

Differing requirements apply for some types of situations and patients, as set out below.

10.9.1. Restraint in emergency situations

In an emergency, where restraint or seclusion is necessary to address an immediate threat to the life, health or safety of the patient or others, consent is not required.

10.9.2. Mental Health patients

No consent is needed to provide treatment to involuntary patients. An authorised medical officer of a mental health facility may give, or authorise the giving of any treatment the officer thinks fit to an involuntary patient.

The *Mental Health Act* also permits an authorised medical officer to take any action that the officer thinks fit to protect a patient or person detained in a mental health facility, or any other person in a mental health facility, from serious physical harm

10.9.3. Minors

Minors assessed as having sufficient understanding and intelligence to understand fully what is proposed, may give their own consent to the treatment or intervention. Where a Minor does not have capacity to provide consent, the consent of their parent or guardian should be obtained.

10.9.4 Patients 16 and over who do not have capacity to consent

Where a patient aged 16 and over lacks capacity, and it is not an emergency, the law requires health practitioners to obtain consent from the patient's Person Responsible (which can include their guardian).

A Person Responsible can consent to medical and dental treatment. Therefore, a Person Responsible can consent to an intervention required to treat a medical condition.

If the purpose of the intervention is not to treat a medical condition (for example, the purpose is to address a behavioral issue), the Person Responsible may not be able to provide consent, and consent from a guardian with a restrictive practices function may be required.

Further guidance

- [NCAT Fact Sheet *Restrictive Practices and Guardianship*](#)

11. Consent tables – quick finders

11.1. Adults with capacity and Mature Minors

Type of treatment for consent	Who can consent	Documentation Required	Relevant Section
Significant procedure or treatment	Patient	Written consent required Form: Consent for Medical Procedure/Treatment	Section 4.5 – Significant procedures or treatments requiring written consent
Minor procedure, examination or treatment	Patient	Written consent not required although strongly advisable for a written note to be included in patient's Health Record	Section 4.6 – Minor procedures or treatments
Research and clinical trials	Patient	HREC approved consent form	Section 10.6 – Research (including clinical trials)
Refusal of treatment	Patient (provided no mental health orders).	Written consent required Form: <i>Procedure / Treatment Refusal Acknowledgement (Patient with Capacity)</i>	Section 6 – Refusal of treatment Section 10.2.1 – Antenatal testing and Screening
Refusal of treatment Advance Care Directive	Patient who had Capacity at the time of making the Advance Care Directive	Written Advance Care Directive required	Section 6.2 – Refusal of treatment using an Advance Care Directive
Discharge against medical advice	Patient	Preferable to get confirmation in writing from patient Form: <i>Discharge against Medical Advice (Adult with Capacity)</i>	Section 6.3 – Discharge against medical advice

11.2. Adults without capacity

Type of treatment for consent	Who can consent	Documentation Required	Relevant Section
Emergency treatment (not previously refused for example by a valid ACD)	No consent required	Documented in the patient's Health Record	Section 4.2.1 - Emergency treatment
Major Treatment under the <i>Guardianship Act 1987</i>	Person Responsible, provided Health Practitioner is not aware of any patient objections If there is no Person Responsible or the Person Responsible is not available or unwilling, then only the NSW Civil and Administrative Tribunal can consent	Written consent required. Form: <i>Consent - Substitute Consent for Medical Procedure/ Treatment</i>	Section 7.7 - Types of treatment under the <i>Guardianship Act</i> and consent requirements
Minor Treatment under the <i>Guardianship Act 1987</i>	Person Responsible can consent The Health Practitioner may treat without consent if the patient is not objecting and there is no Person Responsible or the Person Responsible is not available	Written consent preferable or at least documented in the patient's Health Record	Section 7.7 - Types of treatment under the <i>Guardianship Act</i> and consent requirements
Special Treatment under the <i>Guardianship Act 1987</i>	Only the NSW Civil and Administrative Tribunal, Guardianship Division can consent		Section 7.7 - Types of treatment under the <i>Guardianship Act</i> and consent requirements
Major or Minor Treatment when the patient is objecting	Only the NSW Civil and Administrative Tribunal, Guardianship Division can consent unless: <ul style="list-style-type: none"> • NCAT has made a guardianship order, appointing a guardian with medical and dental consent authority and additional authority to override the patient's objections, and the guardian has provided consent; or • section 46(4) guardianship Act, the patient has minimal or no understanding of what the treatment entails and 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 		Section 7.6 - When is a consent application to the Guardianship Division of the Civil and Administrative Tribunal required?
Medically supervised withdrawal, rehabilitation and other interventions under the <i>Drug and Alcohol Treatment Act 2007</i> for patients with severe substance dependence who lack capacity to consent primarily as a result of substance abuse	An Accredited Medical Practitioner (AMP) who has been authorised by the Secretary, NSW Health	Dependency certificate in the form shown in Schedule 2 of the <i>Drug and Alcohol Treatment Act 2007</i>	Section 4.2.2 - Treatment lawfully authorised or required

Note that in all cases consent from NCAT or otherwise should be recorded in the patient's Health Record.

11.3. Minors

Type of treatment for consent	Who can consent	Documentation Required	Relevant Section
Minor procedure, examination or treatment	Parent/guardian unless the minor is a Mature Minor in which case the Minor can consent	Written consent not required although strongly advisable for a written note to be included in patient's Health Record	Section 4.6 – Minor procedures or treatments
Significant procedure or treatment	Parent/guardian except in rare cases where the Minor is a Mature Minor in which case the Minor can consent, however, the consent of the parent/guardian is still recommended	Written consent required Form: <i>Consent to Medical Treatment (Minor)</i> or <i>Consent to Medical Treatment (Adult or Mature Minor)</i>	Section 4.5 – Significant procedures or treatments requiring written consent
Research and clinical trials	Parent/guardian and assent or agreement from Mature Minor as required by HREC and National Statement. Re-consent the Minor when they turn 18	HREC approved consent form	Section 10.6.1 – Consent for children participating in research or clinical trials
Refusal of treatment	Parent/guardian unless the Minor is a Mature Minor Note, a court may override a refusal made by a Mature Minor or a parent or guardian based on the Minor's best interests	Document all discussions and statements about treatment refusal in the patient's Health Record	Section 8.4 – Can a Minor refuse treatment?
Discharge against medical advice	Parent/guardian unless the minor is a Mature Minor Note, a court may override a decision made by a Mature Minor or a parent or guardian based on the Minor's best interests	Written acknowledgement preferred Form: <i>Discharge against Medical Advice (for parents/guardians of a Minor)</i>	Section 6.3 – Discharge against medical advice
Opioid Substitution Therapy (OST) for patients aged 16-17 ²	Patient with capacity AND 2 supportive medical opinions, one of which should be from an addiction medicine specialist	Dependency certificate in the form shown in Schedule 2 of the <i>Drug and Alcohol Treatment Act 2007</i>	Section 8.11 – What are the legal requirements for 'Special Medical Treatment' in relation to children?

² Minors (aged less than 18 years) cannot access treatment from Medically Supervised Safe Injecting Centres.

11.4. Consent to Medical and Dental Treatment under the *Mental Health Act*

Type of Patient	General Medical and Dental treatment (including mental health treatment)	Emergency Surgery	Non-Emergency Surgery	ECT	Special Medical Treatment' under the <i>Mental Health Act</i>
Voluntary patient with capacity	Patient consent	Patient consent	Patient consent	Patient consent plus <i>Mental Health Act</i> sections 91-94	Patient consent plus <i>Mental Health Act</i> sections 102-104
Voluntary patient without capacity	<i>Guardianship Act</i> part 5 Substitute consent provisions	<i>Guardianship Act</i> part 5 Emergency provisions apply	<i>Guardianship Act</i> part 5 Substitute consent provisions	ECT cannot be provided to a voluntary patient who lacks capacity	<i>Mental Health Act</i> sections 102-104
Assessable patient without capacity	<i>Mental Health Act</i> section 84 or <i>Guardianship Act</i> Authorised medical officer may authorise treatment in accordance with the <i>Mental Health Act</i> section 84	<i>Guardianship Act</i> part 5 Emergency provisions apply	<i>Guardianship Act</i> part 5 Substitute consent provisions	<i>Mental Health Act</i> section 94 Approval of the Mental Health Review Tribunal required	<i>Mental Health Act</i> sections 102-104
Assessable patient with capacity	<i>Mental Health Act</i> section 84 Authorised medical officer may authorise treatment in accordance with the <i>Mental Health Act</i> section 84	Patient consent	Patient consent	<i>Mental Health Act</i> section 94 Approval of the Mental Health Review Tribunal required	Patient's consent and <i>Mental Health Act</i> sections 102-104
Involuntary patients (not including forensic and correctional patients)	<i>Mental Health Act</i> section 84 or <i>Guardianship Act</i> Authorised medical officer may authorise treatment in accordance with the <i>Mental Health Act</i> section 84	<i>Mental Health Act</i> section 99 Authorised medical officer or Secretary of Health may consent if of the opinion that the patient does not have capacity to consent, or has capacity to consent, but refuses to do so, or neither gives nor refuses consent and surgery is necessary as a matter of urgency in order to save the life of the patient or to prevent serious damage to the health of the patient or to prevent the patient from suffering or continuing to suffer significant pain or distress	<i>Mental Health Act</i> sections 100 and 101 Consent by Secretary only if Designated Carer agrees to surgery and patient does not have capacity to give consent to the operation and it is desirable having regard to the interests of the patient to perform the surgical operation on the patient. Application must be to MHRT where Designated Carer has not agreed to surgery. MHRT can only consent where a patient does not have capacity to consent or has capacity to consent but refuses to give consent or neither gives nor refuses to give that consent and it is desirable having regard to the interests of the patient to perform the operation.	<i>Mental Health Act</i> section 94 Mental Health Review Tribunal by way of an ECT Determination following an ECT Administration Inquiry	<i>Mental Health Act</i> sections 102-104 Emergency – if the patient does not have capacity no consent required if Medical Practitioner considers Special Medical Treatment is necessary as a matter of urgency in order to save the patient's life or to prevent serious damage to the patient's health Non-Emergency MHRT may consent if the patient is 16 years or over and Tribunal is satisfied that the Special Medical Treatment is necessary to prevent serious damage to the health of the patient. *Special conditions apply for prescribed Special Medical Treatment

Type of Patient	General Medical and Dental treatment (including mental health treatment)	Emergency Surgery	Non-Emergency Surgery	ECT	Special Medical Treatment' under the <i>Mental Health Act</i>
Forensic and correctional patients with a mental illness	Mental Health Act or Guardianship Act Authorised medical officer may authorise treatment in accordance with the <i>Mental Health Act</i> section 84 or <i>Guardianship Act</i>	Mental Health Act section 99 (see emergency surgery for involuntary patients above)	Mental Health Act sections 100 and 101 (see non-emergency surgery for involuntary patients above)	Mental Health Act sections 94 MHRT by way of an ECT determination following an ECT administration inquiry	Mental Health Act sections 102-104 (see Special Medical Treatment for involuntary patients above)
Forensic and correctional patients without a mental illness	Mental Health Act section 84 Authorised medical officer may authorise treatment in accordance with the <i>Mental Health Act</i> section 84	Mental Health Act section 99 Authorised medical officer or the Secretary of Health may consent if the authorised medical officer or Secretary is of the opinion that the patient does not have capacity to consent to the operation and the surgery is necessary as a matter of urgency in order to save the life of the patient or to prevent serious damage to the health of the patient or to prevent the patient from suffering or continuing to suffer significant pain or distress	Mental Health Act sections 100 and 101 Application for consent by Secretary only if a Designated Carer agrees to surgery in writing. Secretary to consent only if patient does not have Capacity to give consent to the operation and it is desirable having regard to the interests of the patient to perform the surgery Application must be to MHRT where Designated Carer has not agreed to surgery. MHRT can only consent when a patient does not have Capacity to consent to the operation and it is desirable having regard to the interests of the patient to perform the surgery	Mental Health Act section 94 MHRT by way of an ECT determination following an ECT administration inquiry	Patient consent plus Mental Health Act sections 102-104 (see involuntary patients above)

12. Useful Contacts

Department of Communities and Justice

Phone (02) 9377 6000
Email facsinfo@facs.nsw.gov.au
Street address 219-241 Cleveland St, Strawberry Hills NSW 2012
Postal address Locked Bag 10, Strawberry Hills, NSW, 2012
Website <http://www.facs.nsw.gov.au/>
Child Protection Helpline 132 111

Guardianship Division of the NSW Civil and Administrative Tribunal

Phone **Main switch** (02) 9556 7600 or 1300 006 228
Toll free 1800 463928
Email gd@ncat.nsw.gov.au
Street Address NSW Civil and Administrative Tribunal Guardianship Division
Level 6 John Maddison Tower
86-90 Goulburn Street Sydney
Postal address NSW Civil and Administrative Tribunal
Guardianship Division
PO Box K1026, Haymarket NSW 1240
Fax (02) 9555 9049
Website www.ncat.nsw.gov.au

Mental Health Review Tribunal

Phone (02) 9816 5955 or 1800 815 511 (toll free)
Email mhrt-mhrt@health.nsw.gov.au
Street Address Building 40, Digby Rd, Gladesville Hospital, Gladesville NSW 2111
Postal address PO Box 2019, Boronia Park, NSW 2111
Fax (02) 9817 4543
Website www.mhrt.nsw.gov.au

Ministry of Health Legal Branch

Phone (02) 9391 9606
Email NSWH-LegalMail@health.nsw.gov.au
Street address 100 Christie Street St Leonards NSW 2065
Postal address Locked Mail Bag 961, North Sydney, NSW 2059
Fax (02) 9391 9604
Website www.health.nsw.gov.au

The Public Guardian

Phone (02) 8688 2650 or 1800 882 889 (TTY)
Email informationsupport@opg.nsw.gov.au
Street address 160 Marsden St. Parramatta, NSW 2150
Postal address Locked Bag 5116 Parramatta NSW 2124
Fax (02) 8688 9797
Website <http://www.publicguardian.justice.nsw.gov.au>

APPENDIX 1

List of relevant policies and legislation

Legislation

NSW

- *Carers (Recognition) Act 2010*
- *Children and Young Persons (Care and Protection) Act 1998*
- *Children (Detention Centres) Act 1987 (section 27)*
- *Civil Liability Act 2002*
- *Crimes Act 1900*
- *Crimes (Administration of Sentences) Act 1999 (section 73)*
- *Disability Inclusion Act 2014*
- *Drug and Alcohol Treatment Act 2007*
- *Government Information (Public Access) Act 2009*
- *Guardianship Act 1987*
- *Health Practitioner Regulation National Law*
- *Health Records and Information Privacy Act 2002*
- *Health Services Act 1997*
- *Human Tissue Act 1983*
- *Mental Health Act 2007*
- *Minors (Property and Contracts) Act 1970*

Commonwealth

- *Family Law Act 1975*

NSW Health Policy Directives

- *Admitted Patient Election Processes for NSW Public Hospitals - Revised (PD2005_221)*
- *Deceased Organ and Tissue Donation - Consent and Other Procedural Requirements (PD2013_001)*
- *Departure of Emergency Department Patients (PD2014_025)*
- *Responding to Needs of People with Disability during Hospitalisation (PD2017_01)*
- *Genetic Testing (PD 2007_066)*
- *Health Care Records - Documentation and Management (PD2012_069)*
- *Interpreters- Standard Procedures for Working with Health Care Interpreters (PD 2006_053)*
- *Privacy Manual for Health Information*
- *Pregnancy - Framework for Terminations in NSW Public Health Organisations (PD2014_022)*

- *Sexual Assault Services Policy and Procedure Manual (Adult) (PD 2005_607)*
- *Using Resuscitation Plans in End of Life Decisions (PD2014_030)*
- *Your Health Rights and Responsibilities booklet (PD2011_022)*

NSW Health Guidelines

- *Advance Care Directives (NSW) (GL 2005_056)*
- *Advance Planning for Quality Care at End of Life Action Plan 2013-2018*
- *Guidelines for End of Life Decision making (GL 2005_057)*
- *The Guardianship Application Process for Adult Inpatients of NSW Health Facilities (GL2016_026)*
- *Last Days of Life Toolkit*, Clinical Excellence Commission
- *Opioid Treatment Program: Clinical Guidelines for Methadone and buprenorphine Treatment (GL2006_019)*
- *Requirements of the Human Tissue Act 1983 in relation to research and use of tissue (GL2006_021)*

Other useful guides

- NSW Department of Attorney General and Justice *The NSW Capacity Toolkit 2008*
- *United Nation Convention on the Rights of Persons with Disabilities (Article 25.d-Health)*
- NSW Health *End of Life Decisions, the Law and Clinical Practice*
- NHMRC *National Statement on Ethical Conduct in Human Research (2007, updated 2018)*
- Agency for Clinical Innovation *Consumer Enablement: A clinician's guide*
- NSW Health Guideline *Communicating Positively: A guide to Appropriate Aboriginal terminology (GL2019_008)*
- *Teach Back tool*
- New South Wales Civil and Administrative Tribunal Factsheet *Consent to Medical or Dental Treatment*
- New South Wales Civil and Administrative Tribunal Factsheet *Person Responsible*

APPENDIX 2

Consent forms

- A Consent for Medical Procedure/Treatment - (Adult and Mature Minors) - for patients with capacity
- B Consent for Medical Procedure/Treatment (Minors) - for parents/guardians of minors without capacity
- C Consent - Substitute Consent for Medical Procedure/Treatment - *Guardianship Act 1987*
- D Procedure/Treatment Refusal Acknowledgement (Patient with Capacity)
- E Discharge against Medical Advice (Adult with capacity)
- F Discharge against Medical Advice (Parents/Guardian of Minors)

FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____ / ____ / ____	M.O.	
ADDRESS		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Facility:

CONSENT FOR MEDICAL PROCEDURE / TREATMENT (Adults and Mature Minors)

For patients with capacity

If in doubt about the capacity of a minor, refer to section 8 of the Consent Manual for more information and/or escalate to a more senior colleague.

PROVISION OF INFORMATION TO PATIENT

To be completed by Medical Practitioner

I, Dr have discussed with this patient the various ways of treating
(INSERT NAME OF MEDICAL PRACTITIONER)
the patient's present condition including the following proposed procedure/treatment:

(INSERT SITE NAME AND REASONS FOR PROCEDURE OR TREATMENT; DO NOT USE ABBREVIATIONS)

I have informed this patient of the nature, likely results and material risks of the proposed procedure / treatment and of the matters in the section below.

I have assessed this patient to be a minor with capacity to give consent (a 'mature minor') as they have demonstrated sufficient maturity and intellect to fully understand what is proposed. Yes No NA

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

Interpreter* / /20.....
PRINT NAME SIGNATURE DATE TIME Emp ID/Prov No.

PATIENT CONSENT

To be completed by Patient

Dr and I have discussed the present condition and the various ways
(INSERT NAME OF MEDICAL PRACTITIONER)
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 / treatment 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 consent to the procedure/treatment described above for me.

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

DELETE IF NOT REQUIRED *This part must be countersigned by your doctor as acknowledgment of refusal*
*While I consent to the above procedure/treatment, after discussing this matter with the doctor, I **refuse consent** to have the following aspects of the recommended procedure or treatment:*.....
insert objection

.....
SIGNATURE OF MEDICAL PRACTITIONER

I consent I do not consent to a blood transfusion if needed

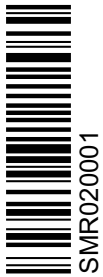
..... / /20.....
SIGNATURE OF PATIENT DATE

..... : AM/PM
PRINT NAME OF PATIENT TIME

* Delete where not applicable

NO WRITING

Page 1 of 1



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NH606006 190319

CONSENT FOR MEDICAL PROCEDURE / TREATMENT (Adults and Mature Minors)

SMR020.001



NSW Health

FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____ / ____ / ____	M.O.	
ADDRESS		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

CONSENT FOR MEDICAL PROCEDURE / TREATMENT (MINORS)

For parents / guardians of minors without capacity

If in doubt about the capacity of a minor, refer to section 8 of the Consent Manual for more information and/or escalate to a more senior colleague.

PROVISION OF INFORMATION TO PATIENT **To be completed by Medical Practitioner**

I, Dr have discussed with this patient's parent/guardian* the
INSERT NAME OF MEDICAL PRACTITIONER
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 nature, likely results and material risks of the proposed procedure / treatment and of the matters in the section below.

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

Interpreter* / /20..... :
PRINT NAME SIGNATURE DATE TIME Emp ID/Prov No.

PATIENT CONSENT **To be completed by Parent/Guardian**

Dr and 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/treatment 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 consent to the procedure/treatment described above for

DELETE IF NOT REQUIRED *This part must be countersigned by your doctor as acknowledgment of refusal*
*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

.....
SIGNATURE OF MEDICAL PRACTITIONER

I note that the Children and Young Persons (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 consent I do not consent to a blood transfusion if needed

..... / /20.....
SIGNATURE OF PARENT/GUARDIAN DATE

.....
PRINT NAME OF PARENT/GUARDIAN RELATIONSHIP TO CHILD OF PARENT/GUARDIAN

.....
ADDRESS

* Delete where not applicable

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CONSENT FOR MEDICAL PROCEDURE / TREATMENT (MINORS)
SMR020.003

FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Facility:

**CONSENT -
SUBSTITUTE CONSENT FOR
MEDICAL PROCEDURE / TREATMENT**

GUARDIANSHIP ACT 1987 (For patients 16 years and above without capacity)

PROVISION OF INFORMATION TO PERSON RESPONSIBLE 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.....

The proposed treatment / procedure 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 with these alternatives are:.....

The proposed procedure/treatment is the most appropriate form of procedure/treatment to promote the patient's health and well-being. and I have discussed the patient's present condition and I have also
NAME OF PERSON RESPONSIBLE

- explained:
- that other forms of procedure/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 MEDICAL PRACTITIONER DATE TIME

Interpreter* /...../20..... :..... Emp ID/Prov No.
PRINT NAME SIGNATURE DATE TIME

SUBSTITUTE CONSENT To be completed by the person responsible

Dr and I have discussed the matters above.
INSERT NAME OF MEDICAL PRACTITIONER

I understand the nature of the procedure / treatment and that undergoing the procedure / treatment carries risk.
 I have had the opportunity to ask questions and I am satisfied with the explanation and answers to my questions.

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

I also consent to anaesthetics, medicines, or other treatments which could be related to this procedure / treatment.
*I understand that another doctor may perform the procedure / treatment.**

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

DELETE IF NOT REQUIRED This part must be countersigned by your doctor as acknowledgment of refusal. 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

SIGNATURE OF MEDICAL PRACTITIONER

I consent do not consent to a blood transfusion if needed

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

.....
PRINT NAME OF PERSON RESPONSIBLE RELATIONSHIP TO PATIENT IN TERMS OF THE ACT

.....
ADDRESS OF PERSON RESPONSIBLE PHONE NUMBER OF PERSON RESPONSIBLE

* Delete where not applicable

NO WRITING

CONSENT - SUBSTITUTE CONSENT FOR MEDICAL PROCEDURE / TREATMENT

SMR020.002



SMR020002

Holes Punched as per AS2828.1: 2012
 BINDING MARGIN - NO WRITING

NH606007 17/12/18



NSW Health

FAMILY NAME

MRN

GIVEN NAME

MALE FEMALE

Facility:

D.O.B. ____/____/____

M.O.

ADDRESS

PROCEDURE / TREATMENT REFUSAL ACKNOWLEDGEMENT (PATIENT WITH CAPACITY)

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Refusal to follow clinical recommendations

To be used in conjunction with local procedure and the NSW Health Consent Manual

PROVISION OF INFORMATION TO PATIENT

To be completed by most senior available Health Practitioner

I, consider this patient has the decision making capacity to refuse the proposed treatment and I have discussed with this patient the nature of the proposed treatment.

NAME AND DESIGNATION OF MOST SENIOR AVAILABLE HEALTH PRACTITIONER

I have informed this patient of the matters as detailed below including the proposed treatment, its nature and likely results:

.....

.....

I have also discussed with the patient the material risks and the possible consequences of refusing the treatment (must be completed):

.....

.....

.....

SIGNATURE OF MOST SENIOR AVAILABLE HEALTH PRACTITIONER

DATE

TIME

Interpreter* /..... /20.....

PRINT NAME

SIGNATURE

DATE

TIME

Emp ID/Prov No.

Where there is doubt about the capacity of a patient to refuse treatment, or there may be serious consequences for a minor seeking to refuse treatment, refer to the Consent Manual, escalate to a more senior colleague, or seek legal advice.

PATIENT REFUSAL

To be completed by patient

..... and I have discussed my present condition.

NAME AND DESIGNATION OF MOST SENIOR AVAILABLE HEALTH PRACTITIONER

I have had the nature of the proposed treatment explained to me as well as the potential consequences if I refuse the treatment.

I have had the opportunity to ask questions and I understand the answers I have been given.

I have been given the opportunity to consult with another health practitioner for a further opinion*.

If so, name of health practitioner providing second opinion:

My decision is informed and I understand the nature and reasons for the proposed treatment. I accept the risks and likely consequences arising as a result of my decision to refuse the proposed treatment.

I hereby do not consent to the above recommended treatment

..... AM/PM

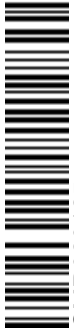
SIGNATURE OF PATIENT

DATE

TIME

If the patient refuses to sign the form, place the partially completed form in the health care record and document in the progress/clinical notes.

* Delete where not applicable



SMR020125

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NH700070 201218

NO WRITING

Page 1 of 1

PROCEDURE / TREATMENT REFUSAL ACKNOWLEDGEMENT (PATIENT WITH CAPACITY)

SMR020.125

FAMILY NAME

MRN

GIVEN NAME

MALE FEMALE

Facility:

D.O.B. ____/____/____ M.O.

ADDRESS

**DISCHARGE AGAINST
MEDICAL ADVICE
(ADULT WITH CAPACITY)**

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

I, am removing
GIVEN NAME FAMILY NAME

myself from (Facility) at my own insistence and against the advice of
attending doctor, clinical or hospital staff at the Facility. I have been informed by:

.....
NAME AND DESIGNATION OF THE MOST SENIOR AVAILABLE HEALTH PRACTITIONER

of the risks associated with leaving the Facility at this time, which include a deterioration and/or worsening of
my condition and health generally. These risks include, but are not limited to:

.....
(IDENTIFY SPECIFIC RISKS OF LEAVING)

I acknowledge that I have been advised that I should remain in the Facility for treatment of my condition. I
understand that there are risks to my health and wellbeing if I leave the Facility. Despite this advice, I agree
to accept these risks and I wish to discharge myself from the Facility. I agree that the Facility and its staff
will not be liable for any harm or damage that may occur due to my decision to leave the Facility.

I have been advised and understand that I should seek medical advice and treatment, including returning to
the Facility, should I have any concerns whatsoever in relation to my health / medical condition.

Date:/...../..... Time: : AM/PM

Print name:

Signature:

Interpreter* /...../20..... :
PRINT NAME SIGNATURE DATE TIME Emp ID/Prov No.

Print name (Health Practitioner):

Designation:

Signature: /...../20..... :
DATE TIME

**If the patient refuses to sign the form, place the partially completed form in
the health care record and document in the progress /clinical notes.**

* Delete where not applicable



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NH700071 07/12/18

**DISCHARGE AGAINST MEDICAL ADVICE
(ADULT WITH CAPACITY)**

SMR010.070

NO WRITING

Page 1 of 1



Health

FAMILY NAME

MRN

GIVEN NAME

MALE FEMALE

Facility:

D.O.B. ____ / ____ / ____ M.O.

ADDRESS

DISCHARGE AGAINST MEDICAL ADVICE (PARENT/GUARDIAN OF MINORS)

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Instructions for Use of This Form

- This form should be used following discussions with the parent/guardian of the patient regarding discharge against medical advice. The form documents the decision of a parent/guardian to discharge a patient at their own risk notwithstanding the knowledge of risks to the patient (as specified on the form) which have been explained to the parent/guardian by the most senior available Health Practitioner (medical practitioner or registered nurse). It also alerts the parent/guardian to the potential for notification to the Child Wellbeing Unit where there are concerns regarding risks to the safety, welfare and wellbeing of a child or young person.
- This form is relevant to all clinical settings including admitted and non-admitted settings where an assessment of the patient has been made by a Health Practitioner.
- This form should **not be used** in the following circumstances:
 - o **Risk of significant harm to patient:** where the relevant Health Practitioner reasonably suspects that the discharge of the patient against advice will put the patient at risk of significant harm. Such circumstances require mandatory notification to the Child Protection Helpline and where necessary, the Police in accordance with NSW Health Child Protection Policies and legal advice;
 - o **No risk of harm to patient:** where the Health Practitioner reasonably considers that the discharge of the patient against advice does not pose any additional real health risk to the patient;
 - o **Mental Health Act 2007 (NSW):** where a patient should be admitted as an involuntary patient under the Mental Health Act;
 - o **Patient with capacity aged 14-17 years discharging at their own risk:** these patients should complete the Discharge Against Medical Advice (Adult with Capacity) form (NH700071). However, it is recommended that the parent/guardian also complete this form. If in doubt about the capacity of a minor, refer to section 8 of the Consent Manual for more information and/or escalate to a more senior colleague;
 - o **Adult without capacity:** please consult the Consent Manual.

Provision of information to parent/guardian by the most senior available Health Practitioner

Print name:

Designation:

I have informed the parent/guardian of the risks of discharge against advice as follows:
(HEALTH PRACTITIONER TO COMPLETE - IDENTIFY SPECIFIC RISKS OF LEAVING THE FACILITY)

.....
.....

I have provided the patient's parent/guardian with the following ongoing care information:

.....
.....

I have considered my obligations under the *Children and Young Persons (Care and Protection) Act 1998 (NSW)* and NSW Health Policies which require mandatory reporting by health care workers where there are reasonable grounds to suspect a child or young person is at risk of significant harm. I have also considered my obligations to contact the Child Wellbeing Unit where there are concerns regarding risks to the safety, welfare and wellbeing of a child or young person.

Signature: Date / / Time: : am/pm

Interpreter* / /20..... : Emp ID/Prov No.

PRINT NAME

SIGNATURE

DATE

TIME

Emp ID/Prov No.

* Delete where not appropriate



SMR010071

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NH700136_031019

DISCHARGE AGAINST MEDICAL ADVICE (PARENT/GUARDIAN OF MINORS)

SMR010.071

NO WRITING

Page 1 of 2



Health

FAMILY NAME

MRN

GIVEN NAME

MALE FEMALE

Facility:

D.O.B. ____/____/____ M.O.

ADDRESS

**DISCHARGE AGAINST
MEDICAL ADVICE
(PARENT/GUARDIAN OF MINORS)**

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Parent/Guardian Acknowledgement (To be completed by parent/guardian)

I, of
GIVEN NAME FAMILY NAME

.....
ADDRESS OF PARENT/GUARDIAN

am the parent/guardian of and
GIVEN NAME OF PATIENT FAMILY NAME OF PATIENT

I am removing the patient from the Facility at my own insistence and against the advice of the Health Practitioner specified on this form. I have been informed by the Health Practitioner of the risks for the patient associated with leaving the Facility at this time, which include a deterioration of the patient's condition and health generally. These risks include, but are not limited to those specified on this form.

I understand that NSW Health Policy requires a Health Practitioner to report to the Child Wellbeing Unit where they have concerns regarding risks to the safety, welfare and wellbeing of a child or young person.

Despite this information and advice, I agree to accept these risks and I wish to discharge the patient from the Facility. I agree that the Facility and its staff will not be liable for any harm or damage that may occur due to my decision to remove the patient from the Facility. I confirm that I have been provided with ongoing treatment information for the patient and I understand that I should seek medical advice and treatment at the Facility or elsewhere should I have any concerns whatsoever in relation to the patient's health/medical condition.

At the time of signing this form I was advised by:
NAME AND DESIGNATION OF HEALTH PRACTITIONER

Date:/...../.....

Signature of Parent/Guardian:

Print Name of Parent/Guardian:

**If the Parent/Guardian chooses not to sign the form, place the partially completed form
in the health care record and document in the progress/clinical notes.**

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

