

Queensland Health
Guide to Informed
Decision-making in
Healthcare



Disclaimer

The information within the *Guide to Informed Decision-making in Healthcare* is intended as a guide to good clinical practice. The law and service delivery environment is constantly evolving, so while every attempt has been made to ensure the content is accurate, it cannot be guaranteed. The information within this document should not be relied upon as a substitute for other professional or legal advice.

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Forward

Patient-centred care is widely recognised as a core dimension of a quality modern health service. Informed decision-making – a two-way dialogue between patients and their health practitioners about the benefits, risks and alternatives of treatment, taking into account the patient’s personal circumstances, beliefs and priorities – is vital to truly patient-centred care. A well informed patient can be an active partner in decision-making about their care, with realistic expectations about the likely or potential outcomes of their treatment and an additional layer of vigilance and protection against errors or adverse events. Performed well, the informed decision-making process builds trust, prevents harm and reduces surprise and distress if complications or adverse events occur.

The provision of informed consent by a patient reflects the end point of a process of engagement in which one or more health practitioners have supported the patient to come to an informed decision to agree to the healthcare offered. While consent forms are often necessary for risk management, completing the form is the final step in documenting the patient’s decision about consent; it is not the entire informed decision-making process.

This Guide to *Informed Decision-making in Healthcare* documents the broadening approach beyond consent to informed patient decision-making in Queensland Health and is intended to be contemporaneous and reflect the national and international ethical, medico-legal and service delivery environment as it applies to Queensland. It guides good clinical practice within the prevailing legal framework in how to implement the principles of informed decision-making in clinical practice. It is not, and cannot be exhaustive.

The Guide reflects the complex ethical, legal, policy and practical framework of contemporary healthcare in which health services are delivered in a multidisciplinary team environment which includes medical practitioners, dentists, nurses, occupational therapists, physiotherapists, and other allied health practitioners, each with differing roles and responsibilities in the provision of healthcare to patients. It also acknowledges that the environment in which health practitioners provide health services continues to evolve in light of changes in modern practice, community expectations, legislation and case law.

In addition to the Guide, the Patient Safety and Quality Improvement Service continues to support and assist healthcare practitioners with the process of informed decision making by providing web-based procedure specific consent forms and corresponding patient information sheets for the most frequently performed procedures performed in Queensland Health.

I would like to personally thank staff of the Patient Safety and Quality Improvement Service, key clinical groups, consumers, legal advisors and other stakeholders for their contribution to the development of this innovative Guide. Finally, I would like to acknowledge and thank Associate Professor, Dr Michael Steyn, Chair of the Informed Consent Reference Group, for his leadership and expertise in the development of this document.

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Introduction

Background

Consistent with good clinical practice, the Queensland Health Informed Decision-making in Healthcare Policy (2011) establishes clear policy support for the rights of patients and their substitute decision-makers to:

- receive and understand information about their healthcare
- make informed decisions, including declining treatment or withdrawing consent at any time
- have their decisions respected.

The 2011 policy reflects a more contemporary, patient-centred, approach than the previous Queensland Health policy, in that it no longer relates simply to ‘informed consent’, ‘invasive treatments’ and ‘medical practitioners’. Instead, it relates to ‘informed decision-making’ in ‘healthcare’, and ‘health practitioners’.

There are several reasons for these changes:

- ‘Informed decision-making’ reflects that the aim is for the patient to make the right decision about healthcare (or for the decision-maker acting on their behalf to do so), considering all circumstances of their life. It is still a successful outcome if a patient receives and understands all information appropriate for them to make a decision, and then decides to decline consent to the healthcare, even if it is considered by the health practitioner to offer the best clinical outcome. Informed decision-making and informed consent terminology can be used interchangeably.
- ‘Consent’ denotes the final decision of the informed decision-making or informed consent process.
- ‘Healthcare’ encompasses the wide range of activities carried out on, and services provided to, patients that are outside of what might be considered ‘treatment’ in a more traditional sense.
- The use of ‘health practitioners’ reflects that, in many instances, healthcare is provided by people other than doctors or dentists. Queensland Health wants patients to be able to make informed decisions about their healthcare, regardless of who is providing it. While some legislation and case law about consent relates specifically to doctors, the policy goes beyond minimum legal requirements, and is intended to reflect current good practice in decision-making in healthcare.

Purpose

This guide has been developed as a reference tool to support practitioners in understanding the complex ethical and legal requirements surrounding informed decision-making about healthcare and in implementing the Queensland Health Informed Decision-making in Healthcare Policy (2011).

The information contained in this document is intended to guide good clinical practice, allowing an appropriate level of flexibility and discretionary professional judgment. It is not to be relied upon as a substitute for specific legal advice or other professional advice.

The law is dynamic and while every attempt is made to ensure the content is accurate, complete and up-to-date, it cannot be guaranteed. If you have a legal query, it is recommended you seek legal advice tailored to your specific circumstance from either your District lawyer or the Queensland Health legal panel.

This guide recognises that healthcare workers and patients have mutual rights and responsibilities concerning informed decision-making with healthcare. The patient’s rights and responsibilities outlined in The Joint Commission’s documents Speak Up series, including ‘Know Your Rights’¹ and ‘Understanding your Doctors and other caregivers’², are supported within this document.

Some issues are beyond the scope of this document, such as the availability of healthcare, and financial issues such as Medicare ineligible patients or overseas students without insurance or funds to pay for healthcare.

Division of the guide

This guide is divided into five main sections.

Part 1 provides general guidance on the process of assisting patients or other people who are legally able to make decisions for the patient (decision-makers) to make informed decisions.

Part 2 relates to informed decision-making and consent for adults who may lack the capacity to make their own decisions.

Part 3 relates to informed decision-making and consent for children and young persons.

Part 4 relates to some healthcare, services and areas of practice that raise specific issues around consent:

- intimate examinations
- mental health patients
- blood and blood product transfusions
- maternity care and terminations of pregnancy
- open access services
- childhood and school-based programs
- public health orders
- ‘off-label’ use of medications
- access to unapproved therapeutic drugs through the special access scheme
- organs for transplantation
- sources of additional advice and contact details for other agencies.

Part 5 relates to communication and cultural issues in informed decision-making in clinical healthcare:

- patients who have communication or cultural needs
- patients with an Aboriginal and Torres Strait Islander background.

What do certain words used in this guide mean?

This guide adopts the same definitions of terms used in the Informed Decision-making in Healthcare Policy and Implementation Standard and a full glossary is provided in the table below. However, it is worth noting some particular points.

The term ‘health practitioner’ is used in the policy, and in this guide, to include all people who have the appropriate registration, accreditation, authority and expertise to assist patients make informed decisions, for example (but not limited to), medical practitioners, dentists, nurses, nurse practitioners, allied health professionals such as physiotherapists and radiotherapists, and dental or oral health therapists. There are other people involved in the provision of healthcare of patients who may not be registered but have the authority and expertise. (Currently, not all allied health professionals are registered, for example, social workers and dieticians). These people work in a professional relationship and/or under the supervision and direction of health practitioners, but are required to adhere to the policy within their defined scope of practice.

1. www.jointcommission.org/Speak_Up_Know_Your_Rights/ [Online: accessed 16 November 2011]

2. www.jointcommission.org/Speak_Up_Understanding_Your_Doctors_and_Other_Caregivers/ [Online: accessed 16 November 2011]

In publications about consent, the terms ‘competence’ and ‘capacity’ are often used interchangeably³. However there is a difference between them:

- A patient’s ‘competence’ to make decisions is determined by the court.
- A patient’s ‘capacity’ to make decisions is determined by a health practitioner after a clinical assessment.

As this guide is intended to assist health practitioners provide healthcare, the term ‘capacity’ is used throughout.

The terms ‘such as’, ‘including’, ‘for example’, are used to illustrate a sample scenario and are not intended to be a full and exhaustive list of possibilities.

3. Kerridge, I, Lowe, I and McPhee, J, *Ethics and law for the health professions*, (2005), 2nd ed., The Federation Press, Sydney p182

Part 1 The general informed decision-making process

1.1 What is 'healthcare'?

In the Informed Decision-making in Healthcare Policy, Implementation Standard and Guide, the words 'healthcare', or 'treatment' are to be interpreted broadly. They describe a range of activities related to the care or treatment of a patient, or a service or a procedure to diagnose, maintain, or treat the patient's physical or mental condition, carried out by, or under the direction or supervision of, a health practitioner⁴. The following examples are considered 'healthcare' within this suite of documents:

- administration of a drug or other similar substance, including chemotherapy
- any physical examination of a patient
- dental or oral health examinations and treatment
- psychological assessment
- interventions such as blood and blood product transfusions
- 'invasive procedures' as defined above, including surgical operations, and oral health interventions
- pathological and radiological investigations or procedures, for example, taking a blood sample or biopsy for analysis
- manipulation or joint immobilisation
- screening undertaken for pathological conditions, for example, breast or bowel cancer
- services provided by the allied health disciplines such as applications of splints or heat packs
- the transfer of a patient to another facility
- clinical trials or medical research.

1.2 What is meant by informed decision-making and informed consent?

Informed decision-making is the two-way communication process between a patient and one or more health practitioners that is central to patient-centred healthcare. It reflects the ethical principle that a patient has the right to decide what is appropriate for them, taking into account their personal circumstances, beliefs and priorities. This includes the right to accept or to decline the offer of certain healthcare and to change that decision. In order for a patient to exercise this right to decide, they require the information that is relevant to them.

Consent is a basic legal principle that reflects a person's agreement to something. In a healthcare context it means a person's agreement to something being performed on them or a sample being taken from them.

Informed consent, in a legal sense, reflects that a patient has received the information relevant to them to make an informed decision and they have given permission for the healthcare to be provided. In an ethical sense the provision of informed consent by a patient reflects the end point of a process of engagement in which one or more health practitioners have supported the patient to come to an informed decision to agree to the healthcare offered.

4. *Guardianship and Administration Act 2000* definition of 'health care'.

For the patient's informed consent to healthcare to be valid, certain principles need to be fulfilled⁵:

- The patient has the capacity (ability) to make a decision about the specific issue at the specific time, and is not affected by therapeutic or other drugs, or alcohol.
- The consent is voluntarily given, and free from manipulation by or undue influence from family, medical staff or other social coercive influences.
- The discussion between the patient and the health practitioner is transparent, well balanced, and involves two-way communication which is sensitive to the situation.
- The patient is able to clearly understand the information because it is provided in a language or by other means the patient can understand.
- As far as possible, the patient is advised in simple terms of:
 - the diagnosis
 - recommended healthcare, including the expected benefits, common side effects and alternative healthcare options
 - the material risks including complications associated with:
 - the recommended healthcare
 - alternative healthcare options
 - a decision not to receive the healthcare offered
 - any significant long term physical, emotional, mental, social, sexual or other expected outcomes
 - the anticipated recovery implications.
- The patient has sufficient time to consider and clarify any information in order to make an informed decision, taking into account the context of the clinical situation.
- The information provided and the consent given relate to the specific healthcare actually provided.

In addition, for the consent to be valid, the healthcare itself must be lawful. The fact that a patient consents to the healthcare does not allow a health practitioner to carry out an unlawful act, for example, an unlawful termination.

Refer to [section 1.6 What process of informed decision-making needs to be followed?](#) for more detail.

1.3 Why is it necessary to obtain consent?

Consistent with ethical and legal principles, it is the patient's decision as to whether or not they wish to submit to healthcare. As a matter of policy, no healthcare (examination, investigation, procedure, intervention or treatment) is provided without the informed agreement of an adult patient who has capacity to make decisions.

In Queensland all persons 18 years and over (adults) are presumed to have capacity to make a decision whether they wish to undergo healthcare or not, except when it can be shown – following an appropriate clinical assessment – they do not have the capacity to make such a decision. This is discussed further in [section 1.7 Is this adult patient able to make a decision about healthcare themselves?](#)

Failure to obtain a patient's consent to healthcare may result in a criminal charge of assault or civil action for battery. In addition, failure to disclose material risks to a patient may give rise to civil action for negligence⁶. In either case disciplinary action may also follow.

5. Kerridge, I, Lowe, I and McPhee, J, *Ethics and law for the health professions*, (2005), 2nd edn, The Federation Press, Sydney pp 215 -236

6. *Consent to Treatment Policy for the Western Australian Health System Second Edition* – May 2009 (amended February 2010) Department of Health Western Australia. [Online: accessed 16 November 2011] www.safetyandquality.health.wa.gov.au/involving_patient/informed_consent.cfm

1.4 What healthcare requires consent?

All health practitioners must obtain consent from an appropriate decision-maker before touching (examining) or providing healthcare to adult and child patients⁷, except in a limited number of circumstances where that is not possible.

The extent of the discussions and information to be provided to patients or decision-makers is described in more detail in the rest of Part 1 of this guide. The remaining sections of this guide give more details of the exceptions or other specific circumstances related to informed decision-making.

What types of consent exist?

1.4.1 Implied consent

The patient indicates their agreement through their actions or by complying with the health practitioner's instructions.

In the case of healthcare without significant risk to the patient, it is usually sufficient to rely on a demonstration of the patient's implied consent by their actions. For example, when providing a routine blood sample for testing, a patient may give implied consent by extending their arm for the insertion of the needle. However, this may not be sufficient where there may be a significant consequence in light of the test result such as for a HIV status test.

Particular care is taken when relying on implied consent as there is the possibility of a misunderstanding leading to an adverse outcome for patient, staff member and Queensland Health.

1.4.2 Explicit/express consent

Express or explicit consent is where the patient clearly states their agreement to healthcare, for example, an examination. This may be verbal or in writing.

Verbal consent

Verbal consent is a form of express consent where a patient says they agree to healthcare.

Written consent

Written consent is where the patient or decision-maker provides written evidence of their agreement to healthcare, for example, by signing a consent form.

The signature on a consent form is not considered to be enough to show the consent is valid and informed. In the event of a dispute about whether a patient had given valid informed consent, a signed consent form needs to be supported by appropriately specific and detailed information, written either on the form or documented in the patient's clinical record, to provide the best evidence of the communication process followed to obtain the patient's consent.

1.5 When should consent be obtained in writing?

Generally, the law does not require consent to be in writing and in many cases it can be verbal or simply implied.

Verbal consent may be appropriate for healthcare that carries no significant risks to the patient, for example, the insertion of an intravenous cannula into a peripheral vein, or a dental filling under local anaesthetic.

7. This includes persons who are offenders (persons incarcerated in prisons)

Written consent is advisable for:

- any healthcare which carries significant risks to the patient
- where doubt exists about the patient's capacity to consent
- where the healthcare is controversial.

It is important to recognise that some discussions need to be sensitively managed, for example, the available end of life treatments and the plan agreed with the patient. In these situations, it is preferable for the health practitioner to have a comprehensive documentation in the patient's clinical record of the discussions held and the decision reached, with supporting evidence.

It is Queensland Health policy that, as a minimum, written consent be obtained for:

- all healthcare where there are known significant risks or complications, such as:
 - treatments or procedures requiring general, intravenous or regional anaesthesia, or intravenous sedation (including surgical, medical, radiology, oncology and endoscopy)
 - procedures or treatment where there are known significant risks or complications associated with the procedure
 - where the patient factors significantly alter the risk profile of the procedure or treatment
- unapproved therapeutic goods accessed via the Special Access Scheme
- oral health procedures and immunisations on children and young persons under the age of 18 years
- administration of a blood or blood products transfusion
- male and female sterilisation
- termination of a pregnancy
- participation in medical research or clinical trials⁸.

1.6 What process of informed decision-making needs to be followed?

Informed consent is not simply about getting a patient's signature on the consent form. It is about the entire interactive communication process for ensuring a patient fully understands the proposed healthcare and has, where appropriate, supportive information to make an informed decision whether to agree or not.

Regardless of whether express or implied consent is to be provided by the patient, the following processes are recommended.

1.6.1 Assessing the information a patient might require

Providing information and education improves patient, family and carer capacity for involvement, understanding, participation and partnership in an individual's care. It can also build an individual's engagement with health practitioners⁹.

8. *Adapted from Consent to Treatment Policy for the Western Australian Health System Second Edition* – May 2009 (amended February 2010) Department of Health Western Australia. [Online: accessed 16 November 2011] www.safetyandquality.health.wa.gov.au/involving_patient/informed_consent.cfm

9. Patient-centred care: Improving quality and safety through partnerships with patients and consumers (2011), Australian Commission on Safety and Quality in Healthcare p21

Care should be taken to avoid assumptions being made about:

- the information the patient or decision-maker might want or need
- the clinical or other factors a patient might find significant
- the level of knowledge or understanding of what is proposed¹⁰.

It is recommended that health practitioners carry out an appropriate assessment of the patient (including a review of the patient's clinical record and discussion with the patient or substitute decision-maker). This will enable them to provide information relevant to the specific circumstances of that patient.

This assessment includes finding out about the patient's:

- needs, wishes and priorities
- medical history
- familial, social and occupational circumstances
- level of knowledge about, and understanding¹¹

During this interaction, if there is any evidence to suggest the patient might not have capacity to provide consent to the particular healthcare concerned, the treating medical practitioner (treating health practitioner in the case of community and primary care settings) is recommended to undertake a thorough assessment of the patient's ability to make a decision as described below in [section 1.7 Is this adult patient able to make a decision about healthcare themselves?](#)

1.6.2 Providing sufficient information so the patient or decision-maker can make an informed decision

The National Health and Medical Research Council (NHMRC) has published detailed guidance to medical practitioners on communicating with patients, and the minimum level of information provided to patients¹². Queensland Health endorses this guidance and encourages all health practitioners to be familiar with it.

The discussions between the patient and health practitioner should be:

- frank and honest
- well balanced
- considerate when giving potentially distressing information
- encourage two-way communication.

Other than in exceptional circumstances, all patients or decision-makers should receive and be able to understand the information likely to influence their decision about whether to agree to the healthcare or not. Consistent with good clinical practice, it is recommended that health practitioners provide – in simple, non medical jargon terms – all the information a reasonable patient (or decision-maker) requires, so they can make a reasonably informed decision about treatment or healthcare advice. This discussion should also include the information the health practitioner knows, or should reasonably know, the patient wants to be given before making a decision^{13,14}.

10. Adapted from *Consent: patients and doctors making decisions together* 2008 p9, General Medical Council [Online: accessed 16 November 2011] www.gmc-uk.org/static/documents/content/Consent_0510.pdf

11. Adapted from *Consent: patients and doctors making decisions together* (2008) p9, General Medical Council [Online: accessed 16 November 2011] www.gmc-uk.org/static/documents/content/Consent_0510.pdf

12. *Guidelines for Medical Practitioners on Providing Information to Patients* (2004); and *Communicating with Patients: Advice for Medical Practitioners* (2004), the National Health and Medical Research Council (NHMRC), [Online: accessed 16 November 2011] www.nhmrc.gov.au/files_nhmrc/publications/attachments/e57.pdf

13. Adapted from *Rogers v. Whittaker* (1992) 175 CLR 479 and *Civil Liability Act 2003* (Qld) - Section 21 Refer to [Background to this suite of documents](#).

14. Refer to [Background to this suite of documents](#).

Following the discussions, the patient should demonstrate they understand, in simple, non-medical jargon terms¹⁵ (by means of audio, verbal, visual, written or multimedia):

- the possible or likely nature of the illness or disease (diagnosis and prognosis)
- the degree of uncertainty about the diagnosis and prognosis, and whether other investigations might reduce this
- the options for investigating, managing or treating the condition, and for each option:
 - what the proposed healthcare involves including its purpose, nature and complexity
 - the potential benefits and likelihood of success
 - the potential complications, risks and long- and short-term side effects, including when a potential adverse outcome is:
 - common even though the harm is slight
 - significant even though its occurrence is rare
 - other consequences, such as any significant long term physical, emotional, mental, social, sexual, or other outcome which may be associated with a proposed intervention
 - the degree of uncertainty about the therapeutic outcome, including whether the intervention is unconventional, experimental or part of a research program
 - the time involved in the healthcare, the recovery period and likely time the patient's function will be restricted
 - the need for follow up
- the likely consequences of not choosing the proposed intervention or healthcare
- the people who will be mainly responsible for and involved in their care and what their roles are
- the extent that trainee/student health practitioners may be involved in their healthcare, and that they have a right to decline to take part in teaching or research
- their right to seek a second opinion
- any conflicts of interests for the practitioner or the organisation
- any bills or out-of-pocket expenses they will have to pay.

1.6.3 How much detail does a patient or decision-maker need to be given?

It is recommended the health practitioner satisfy themselves that the information given is that which:

- a reasonable patient in the circumstances would require, to enable the patient to make a reasonably informed decision to undergo the treatment or follow the advice, and
- the information the health practitioner knows, or ought reasonably to know, that patient wants to be given before making a decision^{16,17}.

This means the health practitioner obtain a sufficiently detailed history about the patient so the information can be tailored to the patient's individual circumstances.

15. *Guidelines for Medical Practitioners on Providing Information to Patients* (2004), the National Health and Medical Research Council (NHMRC), [Online: accessed 16 November 2011] www.nhmrc.gov.au/files_nhmrc/publications/attachments/e57.pdf

16. Adapted from *Rogers v. Whittaker* (1992) 175 CLR 479 and *Civil Liability Act 2003* (Qld) s21

17. Refer to [Background to this suite of documents](#).

The extent of the discussions may vary with ¹⁸:

- the patient's personal circumstances
- the seriousness of the patient's condition and the degree of clinical urgency
- how complex or straightforward the healthcare is
- the likelihood and degree of potential harm
- the patient's temperament, attitude and level of understanding
- the questions asked or additional information sought by the patient
- the patient's cultural and ethnic background.

For healthcare without significant risk to the patient (refer to [section 1.6.7 Healthcare without significant risk to the patient](#)), the discussions may not be as extensive. For complex healthcare interventions, those with greater risks or more uncertainty, and non-therapeutic or research interventions, the discussions may be more wide-ranging.

1.6.4 Presenting information

Patients feel engaged in their own care when they make decisions based on information provided in a form and manner that clearly identifies the issues and healthcare options available to them.

There are various ways in which this can be achieved, for example:

- using methods appropriate to the patient or decision maker's circumstances, personality, expectations, fears, beliefs, disabilities, values and cultural background ¹⁹
- using ways to present information appropriate to that individual's needs, including diagrams, printed, video or aural materials and media
- engaging the services of an interpreter if English is not the patient or decision-maker's first language (Refer to [section 5.1 What about patients who have additional communication needs?](#))
- asking for the assistance of an Indigenous Hospital Liaison Officer if the patient is of Aboriginal and/or Torres Strait Islander origin.

It is recommended that the specific details regarding the use of additional resources (for example, type of media, title, publisher, version number) be recorded in the patient's clinical records or on the consent form.

Taking the overall situation into account (for example, routine versus emergency, minor procedure with minimal risks versus cosmetic with significant risks), before being asked to make a decision, patients need sufficient time to:

- reflect on and clarify the information provided
- consult with those close to them
- be given answers to any questions they might have
- come back to another consultation or seek a second opinion if appropriate.

18. *Guidelines for Medical Practitioners on Providing Information to Patients* (2004), the National Health and Medical Research Council (NHMRC) [Online: accessed 16 November 2011] www.nhmrc.gov.au/files/nhmrc/publications/attachments/e57.pdf

19. *Guidelines for Medical Practitioners on Providing Information to Patients* (2004), the National Health and Medical Research Council (NHMRC) [Online: accessed 16 November 2011] www.nhmrc.gov.au/files/nhmrc/publications/attachments/e57.pdf

Despite the need to provide information to patients, conversations between the health practitioners and patients should be sensitively handled, particularly when providing information of a difficult or distressing nature. For example, in end of life situations, discussions with patients may be phrased in such a way as to emphasise a move towards palliative care rather than continuing futile active treatment.

The information provided in the Queensland Health procedure specific consent forms and patient information documents does not take into account variable factors that may influence the outcome for an individual patient. These factors can include things such as the patient's age, the severity or complexity of the disease or condition, and number of co-morbidities the patient may have. Therefore, the forms have been designed to be used as a general guide when informing patients and decision-makers about the major known risks and complications of the correlating procedure. The specific risks for a particular patient are communicated to patients and decision-makers when distributing the information, and appropriate amendments or annotations made to the document.

Where patients are given information in writing, or through other media, it is not sufficient to rely only on this material. In the interests of best practice, health practitioners should still discuss the significant or material risks with the patient and provide them with an opportunity to have any questions answered.

Further information about communicating with, and providing information to, patients can be obtained from:

The National Health and Medical Research Council (NHMRC):
Guidelines for Medical Practitioners on Providing Information to Patients (2004)
Communicating with Patients: Advice for Medical Practitioners (2004)

1.6.5 Checking understanding

Healthcare professionals can satisfy themselves that the patient or decision-maker understands the information presented by:

- asking them to repeat what has been said using their own words, or asking them questions about the information provided
- providing them with the opportunity to ask questions and ensuring they are answered in a manner they can understand.

If a healthcare practitioner is concerned a patient or decision-maker does not understand the healthcare options well enough to make an informed decision, the practitioner should take reasonable steps to ensure they receive the necessary information before healthcare is provided. This may involve another verbal discussion and/or distributing written, or other visual or aural information.

Where patients have limited communication skills, an appropriate alternative method of communication is required. (Refer also to [section 5.1 What about patients who have additional communication needs?](#))

1.6.6 Obtaining express consent

Even in situations where written consent is not required, it is advised that the health practitioner ensures the patient or decision-maker understands the situation by clearly stating they agree to a particular form of healthcare (for example, examination, assessment, investigation, procedure or treatment).

1.6.7 Documenting the consenting process

Healthcare without significant risk to the patient

Healthcare without significant risks to the patient does not require a written consent form. However, the nature of the healthcare still needs to be explained in sufficient detail and, where applicable, the patient's clinical record, clinical pathway or progress notes should include relevant documentation in relation to consenting discussions.

This might include:

- procedures such as insertion of IV cannulae
- requesting blood tests
- abdominal ultrasound
- urethral catheterisation
- dressings
- child and/or adult health check.

Invasive treatments and healthcare with significant risks

Queensland Health policy requires informed consent be documented using an approved Queensland Health consent form for all private and public patients treated in Queensland Health facilities. This ensures statewide standardisation and minimises potential risks to patients.

A diverse range of patient information sheets and procedure specific consent forms are accessible through the Queensland Health Patient Safety and Quality Improvement Service (www.health.qld.gov.au/consent) [Online: accessed 16 November 2011]. Some of these patient information sheets are available in a range of languages.

These procedure specific forms have been designed as an aide to assist the patient and health practitioner engage in a collaborative process leading to informed decision-making. However, these pre-prepared forms are not designed to be used as a substitute for appropriate communication tailored to the patient's circumstances, and ascertaining whether the patient understands the healthcare and the risks involved in the proposed healthcare.

In situations where a procedure specific consent form is not available, the generic consent form can be used.

Some types of healthcare do not have a statewide document because they are low volume or are only provided in a limited number of facilities – for example, certain physiotherapy treatment plans or specific fetal-maternal procedures conducted only at the Royal Brisbane and Women's Hospital. As an alternative to the statewide generic form, a District-specific consent form maybe used, providing this form has passed through a governance process including a District forms approval committee and a Queensland Health legal approval process.

In the absence of a Queensland Health consent form, the details of the conversation between the patient and health practitioner is considered to be a part of the care given to the patient and as such can be recorded in the patient's clinical record. Some practitioners ask the patient or decision-maker to sign their agreement so the entry in the clinical record accurately reflects the discussions that took place (although there is no legal requirement for them to do so).

Whatever method of documenting the patient's consent is used, it is not enough to simply state 'risks discussed with patient'²⁰. The following information should be documented clearly:

- patient's full name, date of birth and UR Number (if available)
- the condition
- the healthcare to be performed, including the side and site of any treatment or procedure
- the material risks for that individual patient
- the full name, title and the signature of the health practitioner obtaining the consent
- date and time when the consent was recorded.

²⁰. *The Informed Consent Process* p16, the former Medical Defence Association of Victoria Ltd (printed copy undated)

In some situations, the circumstances of an individual patient (for example, the presence of co-morbidities) result in the risks associated with a particular form of healthcare being increased or not included on the Queensland Health consent document. Where specific information relevant to a patient is not present, or is incorrect on a pre-prepared form, the usual practice is to document the correct or relevant information by:

- crossing out any information that does not apply
- adding any additional relevant information
- the health practitioner and patient initialling and dating any addition or amendment.

Many patients are admitted to Queensland public hospitals, either as public, intermediate or private patients by health practitioners exercising their right to private practice including Visiting Medical Officers (VMOs). Such health practitioners (including VMOs) may, at no cost, access the Queensland Health suite of consent forms for use in their private practice.

All medical practitioners eligible to be indemnified by Queensland Health (including in respect of their private patients) under prevailing relevant Queensland Health Policy 21 are required to use Queensland Health consent documentation.

In circumstances where a consent form other than a Queensland Health form has been used, the appropriate Queensland Health form should also be used to re-confirm the patient's consent, and the specific information provided to the patient documented appropriately. For example, when a patient is admitted after providing written consent in a VMO's private rooms, the patient's consent should be re-confirmed on a Queensland Health form. The latter may be annotated to refer to the risks explained as in VMO's consent form, which is attached to the Queensland Health form.

Additional supplementary documentation may be used by health practitioners to assist the consenting process, for example, detailed agreements for plastic surgery, burns, oncology and other complex procedures or treatments. These supplementary documents will then be filed in the patient's medical record with the Queensland Health consent documents and retained, as in [section 1.6.9 Retention of consent documentation](#).

Consent documentation and screening programs

Queensland Health has approved consent forms for screening programs, for example, breast and bowel cancer. These should be used where available.

Consent documentation and clinical trials and research

The Queensland Health Research Management Policy clearly outlines the consent requirements to be obtained from participants. The appropriate approved forms should be used.

(www.health.qld.gov.au/ohmr/html/regu/resrch_mge_policy.asp) [Online: accessed 16 November 2011]

The use of abbreviations

The use of abbreviations on consent documents is not acceptable due to the potential for misinterpretation or misunderstanding. In particular:

- the side or site of any treatment or procedure is to be written in full, for example, 'Right' instead of 'R' or 'Rt'²²
- fingers are to be identified by name and not number, that is, thumb, index, middle, ring and little finger
- the healthcare (procedure) is to be written in full.

21 At the time of publication this is the Indemnity for Queensland Health Medical Practitioners Human Resources Policy I2 (2009)

22. Queensland Health, Ensuring Correct Patient, Correct Site and Side, Correct Procedure (3Cs) Policy and Implementation Standard 3Cs Policy <http://qheps.health.qld.gov.au/psq/3cs/docs/3cs-policy.pdf> [Intranet Queensland Health staff only]

3Cs Implementation Standard <http://qheps.health.qld.gov.au/psq/3cs/docs/3cs-standard.pdf> [Intranet Queensland Health staff only]

1.6.8 Consent documentation and patient transfer

When transferring a patient, the original written consent document for the proposed healthcare needs to accompany the patient to the facility where the healthcare is to be provided. A copy of the consent form may be retained in the patient's clinical record at the referring facility.

However, the treating health practitioner remains responsible for ensuring appropriately informed consent has been given before providing healthcare. If the healthcare plan or material risks change before the healthcare is provided, a new consent process is commenced and documented.

Rarely, there may be situations where the original consent to healthcare document is not available at the time of the healthcare being provided to the patient in the receiving facility, and it is not possible to obtain the original or a fresh consent document. In such situations, a faxed or photocopied consent document can be used – as an interim measure only. Arrangements to forward the original documents are made as soon as possible. The original (and copy if it has been relied on) are filed in the patient's clinical record at the facility where the healthcare is delivered as soon as it has been received.

1.6.9 Retention of consent documentation

All signed consent forms and any supplementary documents are to be filed in the patient's Queensland Health clinical record at the facility where the healthcare is provided. All original consent forms are to be retained as part of the patient's clinical record in accordance with Queensland Health Retention and Disposal of Clinical Records Policy. Visit http://qheps.health.qld.gov.au/clinical_info_mgt/docs/9442_ret_st_dis.pdf

Where relevant, the following records should also be documented, filed and retained in the patient's clinical record:

- a certified copy of any Advance Health Directive or Enduring Power of Attorney document
- details of any guardian, Enduring Power of Attorney or Statutory Health Attorney (their name, relationship to the patient, contact details and, if relevant, any evidence used to identify them as such)
- details of any information aids used such as printed, aural, or video information resource material; as a minimum this could include the title, source, date and/or version number, but in some limited circumstances, it may be more appropriate to file a copy of the original material
- additional information required by specific legislation, such as that required by s63(4) of the *Guardianship and Administration Act 2000* when providing urgent healthcare, or when administering a blood transfusion to a child without consent under s20 of the *Transplantation and Anatomy Act 1979*
- additional information consistent with good practice, or professional standards or codes of professional conduct.

Where an interpreter has been used, refer to [section 5.1 What about patients who have additional communication needs?](#)

1.7 Is this adult patient able to make a decision about healthcare themselves?

This section is based on the Queensland Health, [End of Life Care: Decision-Making for Withholding and Withdrawing Life-Sustaining Measures from Adult Patients, Implementation Guideline Part 1, section 2.4](#)²³ and the reader is referred to the original for more detailed discussion. [Intranet Queensland Health staff only.]

In law, all adults are presumed to have capacity to decide whether they wish to receive healthcare or not, except when it can be shown that they lack the capacity to do so.

23. Queensland Health, End of Life Care: Decision-Making for Withholding and Withdrawing Life-Sustaining Measures from Adult Patients, Implementation Guideline Part 1, section 2.4 <http://qheps.health.qld.gov.au/policybranch/html/ethicsteam.htm>. [Intranet Queensland Health staff only]

In Queensland legislation ²⁴, capacity means a person is capable of:

- understanding the nature and effect of decisions about a matter and
- freely and voluntarily making decisions about a matter and
- communicating the decisions in some way.

To give valid informed consent, a patient needs to have the capacity to do so, which can be demonstrated by the patient's functional ability ²⁵ to:

- express a choice
- understand information relevant to healthcare decision-making
- appreciate the significance of that information for their own situation, especially concerning their illness and the probable consequences of their healthcare options
- use relevant information to reason so as to engage in a logical process of weighing up the healthcare options.

It should not be assumed that a patient lacks capacity to make a decision solely because of their age, disability, appearance, behaviour, medical condition (including mental illness), beliefs, apparent inability to communicate, or the fact they make a decision the health practitioner disagrees with. Health practitioners work on the presumption that every adult patient has the capacity to decide whether to agree to or decline healthcare (including an examination, investigation or any form of treatment) except when it can be shown by a clinical assessment they do not have the capacity to make such a decision.

Consideration should be given as to whether the patient has capacity to consent to or decline healthcare on all occasions. In the majority of cases, there is often little doubt and a detailed clinical assessment may not be required. However, if during the general care of the patient, or discussions with them, there is a suspicion the patient may not have the capacity to consent, a specific assessment can be undertaken and appropriately documented in the patient's clinical record.

Any question as to whether the patient lacks capacity to make a valid informed decision is resolved by the medical practitioner responsible. If a medical practitioner is not engaged in the client's care at the time of informed decision-making (such as in some community, primary care or outpatient situations), a consultation from a suitable qualified and experienced medical practitioner such as a geriatrician, psychiatrist or neurologist is suggested.

Simply because a patient makes a decision that a health practitioner disagrees with does not mean the patient lacks capacity. Patients with capacity are free to make decisions that are likely to result in harm to themselves and even their death.

The extent of the evidence required to support the clinical assessment of a patient's decision-making ability can vary depending on the specific healthcare and the specific time taking into account the patient's circumstances and the healthcare proposed.

Section 2.4 of the Queensland Health End of Life Care: Decision-Making for Withholding and Withdrawing Life-Sustaining Measures from Adult Patients, Implementation Guideline Part 1 states:

Generally, a patient can be regarded as having decision-making capacity if they meet the following five criteria:

1. *Does the patient understand the basic medical situation?*
2. *Does the patient understand the nature of the decision being asked of him or her?*
Understanding includes the following:

24. Powers of Attorney Act 1998 (Qld) and Guardianship and Administration Act 2000 (Qld)

25. Grisso, T. & Aplebaum, P.S. (1998), *Assessing Competence to Consent to Treatment: A guide for physicians and other health professionals*, Oxford University Press: NY. (pp. 31-33) in Queensland Health, End of Life Care: Decision-Making for Withholding and Withdrawing Life-Sustaining Measures from Adult Patients, Part 1, p11. Implementation Guideline <http://qheps.health.qld.gov.au/policybranch/html/ethicsteam.htm>. [Intranet Queensland Health staff only]

- *implications – benefits, risks, what the treatment entails*
 - *alternatives and their implications, including the implication of no decision*
 - *retaining the information (short-term memory function) sufficient to make a decision.*
3. *Can the patient use or weigh that information as part of the process of making the decision (for example, asking questions)?*
 4. *Can the patient communicate a decision (for example, by talking, using sign language or any other means)?*
 5. *Is the patient communicating the decision voluntarily (for example, is there an absence of coercion, undue influence or intimidation by the patient's family/ decision-maker/s.)?*

A multidimensional approach to the assessment may be necessary, and can include:

- discussions with those close to the patient, such as their family or carers, who may be aware of the patient's usual ability to make decisions and their particular communication needs
- consultation with health professionals caring for the patient, such as nurses, speech and language therapists
- communicating with the patient with the support of toolkits, including pictures or flash cards (these may be available through social workers or community liaison officers).

People suffering from a mental disorder (even when subject to an involuntary treatment order) may still have capacity to make decisions about certain aspects of their healthcare, and an assessment of their capacity on a specific issue at a specific time is often made, as above. (Refer also to section [4.2 What are the consenting issues for mental health patients?](#))

For further detailed discussion, refer to the Queensland Health Withholding or Withdrawing Life-Sustaining Measures Policy and additional Implementation Guidelines accessible through the Clinical Policy Unit Ethics Team website at: <http://qheps.health.qld.gov.au/policybranch/html/ethicsteam.htm>

In particular refer to section '3.2 Advance Health Directives' of the End-of-life care: Decision-making for withholding and withdrawing life-sustaining measures from adult patients - Implementation Guidelines - Part 1. <http://qheps.health.qld.gov.au/policybranch/docs/lsmguide1.pdf> [Intranet Queensland Health staff only.]

1.8 What if there is doubt about a patient's capacity to consent, or it appears borderline or fluctuates?

It may be difficult to assess whether an individual patient can make valid decisions on very serious issues when they have borderline or fluctuating capacity. For example, a patient may be capable of making decisions about minor healthcare, such as the application of a dressing or simple analgesia for a headache, but may not be able to understand the implications of more complex or significant healthcare which involves greater risks or complexity.

Most issues surrounding capacity can be resolved by the medical practitioner responsible for the patient's care. However, there may be times when doubt persists or consensus cannot be reached within the healthcare team. In these circumstances the medical practitioner should consider obtaining a second opinion or psychiatric evaluation from a suitably qualified and experienced medical practitioner such as a geriatrician, psychiatrist or neurologist.

Where a patient's condition fluctuates such that they are intermittently unable to make decisions for themselves, the following should be considered ²⁶:

- if the clinical condition allows, deferring the healthcare until such time as the patient is able to make a decision
- repeating the assessment on a number of occasions at times when the patient appears best able to understand and retain the information
- involving those people whom the patient considers might help them reach a decision
- seeking the views of those who personally know the patient well on the patient's ability to decide, and best ways of communicating with the patient
- using different communication methods
- recording any decisions made at times when the patient has capacity
- any previous views expressed directly to the clinical team or documented in the clinical records by the patient when they had capacity, including through a valid Advance Health Directive
- seeking advice from suitably experienced specialist medical practitioners as above.

Where a patient has consented to treatment or a procedure and has subsequently lost capacity prior to the treatment or procedure being carried out, the consent is invalid. Refer to [section 2.2 Who can consent for adult patients who lack capacity to make a decision about healthcare? \(Substitute decision-makers\)](#).

1.9 Can a patient or decision-maker decline or withdraw consent to healthcare?

Any patient who has capacity to consent may also decline any or all healthcare at any time, even when this is contrary to medical recommendations and in circumstances where such a decision to decline healthcare may result in the death of the patient. Where a patient lacks the capacity to make healthcare decisions, their decision to decline healthcare may be made known by a valid Advance Health Directive, made at a time when they had capacity to make their wishes about future healthcare known. (Refer to [section 2.2.1 What are Advance Health Directives and when do they apply?](#) for more details.)

A patient may also change their mind or withdraw consent at any time, for example, they may want to delay the whole or part of their treatment. The declining or withdrawal of consent can be orally or in writing. This declining or withdrawal of consent may be on the grounds of religious, cultural or other personal beliefs or any other reason.

A patient's decision to decline or withdraw consent is to be communicated to the medical practitioner or treating health practitioner responsible for the patient.

Generally, a patient's healthcare decision is to be respected. However, when a patient declines or withdraws consent, the following should be considered:

- confirming the patient has capacity to make the decision
- checking the patient's understanding and looking for any health literacy or communication issues
- exploring the reasons for the decision including:
 - a refusal or an inability to sign the form

26. Modified from *Consent: patients and doctors making decisions together* (2008) p28, General Medical Council, [Online: accessed 16 November 2011] www.gmc-uk.org/static/documents/content/Consent_0510.pdf

- any cultural or religious conflict that the patient may have
- exploring other healthcare options that might be acceptable to them.

Where necessary, provide further explanation of the healthcare and consequences using different methods and additional supporting material.

If a patient who has capacity to make decisions continues to decline or withdraw consent, the following can be part of subsequent discussions:

- the consequences and risks of the decision, including how it affects their healthcare choices, prognosis or outcomes
- that they are entitled to a second opinion and how the health practitioner can facilitate this
- their decision to decline or withdraw consent for a specific procedure/treatment does not affect the provision of other appropriate healthcare and access to health services.

The health practitioner would then attempt to confirm their understanding of the information provided.

The patient's decision to decline or withdraw consent to a specific form of healthcare, and any known reasons, is to be clearly documented in the patient's clinical record. The patient can be asked to sign the entry in the clinical record to confirm it is factually correct, although there is no legal requirement for them to do so.

Substitute decision-makers may also decline or withdraw consent. Such a decision is to be explored and acted on in the same manner as if a patient had made the decision. However, legal advice may be needed if there is concern:

- the decision-maker seemed unwilling to listen to advice or recommendations from the healthcare team
- the decision was contrary to the best interests of the patient ²⁷
- the decision does not take into account the patient's views and wishes
- there was a potential conflict of interest for the decision-maker, for example a family member who might benefit from the decision.

1.10 Can information be withheld from a patient?

1.10.1 The health practitioner wishes to withhold information

Best practice indicates that health practitioners provide appropriate information to patients as detailed in [section 1.6.3 How much detail does a patient or decision-maker need to be given?](#) If information deemed by others to be appropriate, particularly about the material risks of healthcare, is not provided to patients, it may form the basis of a claim in negligence.

Providing decision-making information to patients may cause some degree of anxiety and stress. However, in the vast majority of situations, it will be necessary to provide this information and it will not seriously harm the patient's mental or physical health. It is not usual practice to withhold information from a patient who has capacity to make decisions about their healthcare simply because they might decide to decline the healthcare, or a relative, partner, friend or carer requests the patient not be told.

If a health practitioner considers a patient's physical or mental health might be seriously harmed by the provision of certain information, the treating medical practitioner is informed, and can review the patient. After careful assessment, if the medical practitioner believes providing relevant information to a patient might result in serious harm to the patient's mental or physical health, to the extent that it might be justified to withhold it during the consenting process, the medical practitioner should consider obtaining a second opinion from a senior or more experienced medical practitioner.

²⁷ *Guardianship and Administration Act 2000 Schedule 1.*

The general ethical principle that medical practitioners can withhold information from patients if they judge, on reasonable grounds, that the patient's physical or mental health might be seriously harmed by the information²⁸ may not be sufficient to overcome the obligations to disclose information arising from the *Civil Liability Act 2003* in Queensland (refer [section 1.6.3 How much detail does a patient or decision maker need to be given?](#)). In these rare circumstances, it is recommended that the medical practitioner seek legal advice.

All circumstances surrounding the withholding of information from patients are usually documented in the patient's clinical record.

1.10.2 The patient does not wish to be given information^{29, 30}

Patients sometimes say they do not want information about the healthcare or risks, and expressly direct a health practitioner to make the decisions for them. In these circumstances, the healthcare practitioner should explain to them it is important they understand what the healthcare will involve and the options open to them, and try to find out why they do not wish to be given the information.

If they still do not wish to be given the information, the patient's wishes are respected but the health practitioner should still consider providing them with basic information about the illness and the proposed healthcare. This is likely to include:

- what the healthcare aims to achieve
- what the intervention will involve, for example:
 - whether the healthcare is invasive
 - what level of pain or discomfort they might experience, and what can be done to minimise it
 - anything they can do to prepare for the healthcare
 - whether it involves any serious risks.

The health practitioner can also:

- consider whether the patient's decision arises due to language difficulties and whether an interpreter should be used
- consider whether it may be appropriate to defer the healthcare so the patient has time to reflect and consult with those close to them, or to arrange for them to have someone present to support them when they are given the information
- explain the consequences of them not having the information
- make it clear to the patient that more information is available, which can be shared with them and they have a right to receive this
- make it clear that the patient can change their mind and receive more information at any time
- consider offering another consultation when they might have further discussions with the patient.

Except for simple healthcare without significant risks, the health practitioner will need to inform the treating medical practitioner responsible for the patient, so they discuss the situation with the patient before making a decision whether to proceed.

Such decisions are documented, along with the patient's consent to proceed without detailed information. The patient's decision should be reviewed over time to ensure that there has been no change of mind.

28. *General Guidelines for Medical Practitioners on Providing Information to Patients* (2004) p12, the National Health and Medical Research Council (NHMRC) [Online: accessed 16 November 2011] www.nhmrc.gov.au/files_nhmrc/publications/attachments/e57.pdf

29. *General Medical Council Consent: patients and doctors making decisions together* (2008) p11. 9 [Online: accessed 16 November 2011] www.gmc-uk.org/static/documents/content/Consent_0510.pdf

30. *Communicating with Patients: Advice for Medical Practitioners* (2004) p11, the National Health and Medical Research Council (NHMRC) [Online: accessed 16 November 2011] www.nhmrc.gov.au/files_nhmrc/publications/attachments/e57.pdf

Legal advice is usually sought if the patient's decision to decline information might make their consent invalid in relation to healthcare which:

- has significant risks
- is non-therapeutic
- is for research
- is unconventional.

1.11 What is the lifespan of a written consent?

Patients may sign a consent form some time before the specific healthcare is provided for a number of reasons, including during an outpatient consultation or pre-admission clinic. They might also have consented to a course of multiple treatments or procedures over a period of time (for example, radiotherapy or chemotherapy).

Queensland Health accepts a signed consent document as valid for 12 months, providing that at the time of receiving any healthcare:

- the patient still has capacity to make a decision
- the patient is able to recall the information previously provided and confirms their consent
- there has been no significant change in health status (including improvement or deterioration)
- there has been no significant change in the nature of intended healthcare or outcome (for example, a move to palliative care rather than curative treatment)
- the patient has not withdrawn their consent and does not question their decision
- new information has not become available: for example, new technology or new treatments, or revised guidelines.

The health practitioner (refer to [section 1.12 Who is responsible for obtaining patient consent in an environment of shared care and multidisciplinary teams?](#)) should take appropriate steps to confirm the above, and if the criteria are not met, a fresh process of obtaining consent including the signing of a new document is carried out.

As a general principle, a review of the patient's consent to the specific healthcare is required whenever the patient's care plan is reviewed, changed or updated; and a new consenting process is required when there is a change in the risks or benefits of healthcare or the options available. Evidence of the review is appropriately documented in the patient's clinical record.

Refer also to [section 4.3 Blood and blood products transfusion](#) in this guide.

1.12 Who is responsible for obtaining patient consent in an environment of shared care and multidisciplinary teams?

1.12.1 General

Informed decision-making, and informed consent in particular, is not simply about getting a patient's signature on the consent form. It involves the entire interactive communication process ensuring a patient has received appropriate, supportive, information and fully understands the proposed healthcare and potential consequences, enabling them to make an informed decision. In many instances, this process starts with the referring health practitioner and continues through the patient's journey as a hospital out-patient and in-patient.

It is acknowledged that teamwork is a critical component of how health services are delivered by a multidisciplinary team and that various health practitioners are involved in the patient's decision-making process over a number of interactions. They may be involved in preliminary discussions, education, screening and/or preparation of the patient prior to the specific healthcare being provided.

As members of the team providing healthcare to a patient, each individual health practitioner is responsible for their own actions in relation to assisting patients make informed decisions and ensuring they act within any legislative requirements, defined scope of practice and professional codes of conduct.

It is beyond the scope of this guide to define the extent of an individual health practitioner's responsibility in relation to informed decision-making on each occasion. This will be shaped by the specific circumstances at hand, including the local practice scope and model of care agreed locally. In some situations, a health practitioner may be acting autonomously as the treating health practitioner, but on other occasions as a delegate of more a senior health practitioner. For example, in some situations a nurse practitioner or midwife may act as a delegate to provide information on behalf of another health practitioner. However, in a different situation, they may act autonomously as the independent health practitioner responsible for assisting the patient make informed decisions about healthcare they will provide themselves.

In many instances, there is a shared responsibility for providing information to patients. However, as a general principle, the health practitioner who provides the healthcare will ultimately be responsible for ensuring:

- a patient or decision-maker has received sufficient, appropriate information to make an informed decision, including information about the potential risks and benefits of the proposed or recommended healthcare and any alternatives
- a patient or decision-maker has given valid informed consent prior to the healthcare being provided
- relevant evidence of the consent is appropriately documented.

For example, a surgeon may refer a patient to a stoma therapist to receive more information about a stoma which would result as part of a proposed surgical procedure. The stoma therapist may meet with the patient and their carer and provide detailed information which the patient would consider when making a decision. The stoma therapist would be responsible for the information they provide. However, the surgeon is expected to have a discussion with the patient afterwards to ensure they have received the information necessary for them to make an informed decision, depending on their individual circumstances (refer to [section 1.6 What process of informed decision-making needs to be followed?](#)). The surgeon should also ascertain whether the patient has any questions and receive answers to these before the procedure is carried out.

Where it is acceptable to rely on a patient's implied consent to receiving healthcare, the health practitioner recommending or providing the healthcare (for example, a registered nurse or radiographer) is usually the person responsible for ensuring the patient understands the proposed healthcare and consents either verbally or through their actions. The practitioner is also responsible for ensuring the healthcare is appropriately documented. (Refer also to [section 1 The general informed decision-making process](#)).

For those specific forms of healthcare requiring written consent as listed in [section 1.5 When should consent be obtained in writing?](#), the senior health practitioner on the treating team has the overall responsibility for ensuring appropriately informed written consent has been provided within the delegation framework described below.

1.12.2 Health practitioners and delegation

Where a senior health practitioner delegates the task of obtaining consent to a junior health practitioner, the senior health practitioner remains responsible for:

- their decision to delegate the task and the overall supervision of the delegate
- taking reasonable steps to ensure the delegate health practitioner obtaining consent:
 - is skilled to undertake the task
 - fully understands the healthcare to be provided and is sufficiently knowledgeable about the healthcare to communicate with the patient
 - discloses relevant information in accordance with the requirements for informed decision-making
 - obtains valid informed consent and documents it appropriately before the healthcare is provided

- respecting the decision of and supporting a delegate who indicates they do not have sufficient knowledge, skills or experience to undertake the task.

A delegate health practitioner:

- recognises and works within the limits of their professional competence and defined scope of practice
- carries out the task in order to fulfil their legal and professional responsibilities to obtain valid informed consent
- ensures any consent form is completed and the consent appropriately documented in the patient's clinical record
- documents their name and position legibly on the consent form and in the clinical record
- declines the task or request support to undertake the consenting discussion if any of the following apply:
 - they feel they have insufficient skills, experience or knowledge to undertake the task
 - the task is outside of their defined scope of practice
 - they feel they do not fully understand the nature and risks of the healthcare to be provided
- notifies the appropriate senior health practitioner in a timely manner of any decision to decline a consenting task, so that appropriate steps can be taken to obtain valid informed consent.

When a senior health practitioner delegates healthcare provision to another health practitioner, the delegate applies the principles of informed consent prior to providing the healthcare. For example, where a senior registered nurse asks a more junior registered nurse to catheterise a patient, the junior nurse is responsible for ensuring the patient makes an informed decision.

Where a specific form of healthcare is to be provided or performed by a medical practitioner, the task of informing a patient about the material risks of the healthcare, and of obtaining consent, cannot be delegated to administrative staff or other health practitioner except where specified in this section.

1.12.3 Medical practitioners and delegation

Senior medical practitioners carry overall responsibility for the patients under their care. In many instances, they delegate tasks to other health practitioners. In these instances, the consultant/specialist remains responsible for their decision to delegate these tasks and for ensuring those working in their team are appropriately supervised to perform the tasks to the appropriate standard. An example might include where specialists screen referral letters from general practitioners and allocate them to a pathway of care that will be delivered by an allied health professional such as physiotherapist.

When the senior medical practitioner delegates healthcare provision to another health practitioner, the delegate applies the principles of informed consent prior to providing the healthcare. For example, some medical practitioners have 'standing orders' that can be actioned by junior medical practitioners or registered nurses when set documented criteria are met. The delegate ensures the patient makes an informed decision and consents before providing the healthcare described in the 'standing orders'.

In situations where the medical practitioner undertaking the consent discussion process is not the medical practitioner who will provide the healthcare, the senior medical practitioner remains responsible as detailed in [section 1.12.2 Health practitioners and delegation](#) above.

For example, where a consultant delegates a surgical procedure to the registrar, and the junior house officer (JHO) carries out the consenting discussions. In such circumstances:

- The JHO is responsible for accepting and carrying out the consenting discussion.
- The registrar is responsible for:
 - the decision to delegate the consenting task to the JHO and the overall supervision of the JHO
 - ensuring that the patient has given valid informed consent before undertaking the procedure.

- The consultant or senior doctor is responsible for the decision to delegate the tasks (consent and surgical procedure) and carries overall responsibility for supervising the juniors and ensuring they carry out the tasks appropriately.

1.12.4 Midwives

Midwives are registered health practitioners who have successfully acquired the requisite qualifications to be registered by the Nursing and Midwifery Board of Australia to practice midwifery ³¹.

It is recognised that midwives work in a variety of metropolitan, rural or remote locations and within different models of care. They may be the health practitioner responsible for a particular woman's care during pregnancy, labour, birth and in the early weeks after the baby is born ³².

Midwives are expected to meet the standards described in this guide when assisting patients or decision-makers make informed decisions about healthcare provided to a woman or her baby. Depending on the circumstances, a midwife may be the treating health practitioner responsible for informed decision-making, or a delegate acting on behalf of a senior health practitioner.

Midwives obtain valid informed consent for all healthcare they provide, acting within the limits of their individual competence ³³, authorisation, specific defined scope of practice and relevant legislation.

Student midwives work within the requirements of section [1.12.6 Trainee/student health practitioners](#) with respect to informed consent.

1.12.5 Nurse practitioners

Nurse practitioners are registered nurses educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The title 'nurse practitioner' is protected in Australia under Section 95 of the *Health Practitioner Regulation National Law Act (Queensland)*. These health practitioners are endorsed by the Nursing and Midwifery Board of Australia and are authorised to undertake extended practice activities.

Nurse practitioners work in a range of metropolitan, regional, rural and remote health services and clinical settings across different models of care. Nurse practitioners are expected to meet the standards described in this guide when assisting patients to make informed decisions about their healthcare. Depending on the circumstances, a nurse practitioner may be the treating health practitioner responsible for informed decision-making, or a delegate acting on behalf of a senior health practitioner.

Nurse practitioners obtain valid informed consent for all healthcare they provide, acting within the limits of their individual competence ³⁴ and specific defined scope of practice determined by the context in which they are authorised to practice ³⁵.

31. *Code of Ethics for Midwives in Australia* (2008) – Australian Midwifery Council – Approved by the Nursing and Midwifery Board of Australia. [Online: accessed 19 August 2010] www.nursingmidwiferyboard.gov.au/Codes-and-Guidelines.aspx

32. *Queensland Health Midwifery models of care: Implementation guide 2008* <http://www.health.qld.gov.au/nmoq/midwifery/guideline.asp> [Online: accessed 16 November 2011]

33. A midwife's competence in relation to the healthcare they are performing shall be assessed within the frame work of the National Competency Standards for the Midwife published by the Australian Nursing and Midwifery Council and endorsed by the Nursing and Midwifery Board of Australia. www.nursingmidwiferyboard.gov.au/Codes-and-Guidelines.aspx

34. A nurse practitioner's competence in relation to the healthcare they are performing shall be assessed within the frame work of the national registration standard and National Competency *Standards for the Nurse Practitioner* published by the Australian Nursing and Midwifery Council and endorsed by the Nursing and Midwifery Board of Australia [Online: accessed 16 November 2011] www.nursingmidwiferyboard.gov.au/Codes-and-Guidelines.aspx

35. *National Competency Standards for the Nurse Practitioner* (2006), Published by the Australian Nursing and Midwifery Council and endorsed by the Nursing and Midwifery Board of Australia [Online: accessed 16 November 2011] www.nursingmidwiferyboard.gov.au/Codes-and-Guidelines.aspx

1.12.6 Trainee/student health practitioners

The presence of a patient in a teaching environment does not imply they consent to being examined or receiving healthcare from a trainee or student health practitioner.

A patient needs to have sufficient information to make an informed decision and give valid consent before trainee/student health practitioners conduct an examination or provide healthcare. This means ensuring:

- trainee/student health practitioners are introduced in a way that makes it clear they are trainees/students and not registered health practitioners (misleading terms such as ‘doctor/physiotherapist in training’ are not to be used)
- patients know they have a right to decline to give consent to the trainee/student examining or providing healthcare to them
- trainee/student health practitioners work within the limits of their professional competence and are appropriately supervised at all times.

While trainee/student health practitioners may assist in the process of obtaining consent, the responsibility for ensuring patients give valid informed consent rests with the health practitioner as detailed above. Any interaction about consent between the patient and trainee/student should take place in the presence of the treating health practitioner, so they can become involved as necessary.

1.13 What are the organisational responsibilities of the healthcare facility?

The goal of Queensland Health is to have a standardised approach to the consenting process (particularly for invasive procedures/treatments and other healthcare with significant risks). A comprehensive suite of procedure specific consent forms is available on the Informed Consent website (www.health.qld.gov.au/consent) [Online: accessed 16 November 2011].

Likewise, it is recognised that some flexibility is required at the operational level to accommodate the diversity of patients and practices, whether they be from metropolitan, rural or remote areas.

For all invasive treatments, as outlined in [section 1.5 When should consent be obtained in writing?](#) of this guide, it is the responsibility of the healthcare facility to have policies and processes in place to ensure the patient’s consent has been obtained and documented prior to:

- the patient’s admission to hospital (this is not always possible)
- pre-medication being administered and
- transfer to the operating theatre, diagnostic unit or medical imaging department ³⁶.

This means that documented evidence of the consenting process will usually be required to be available for checking before a patient is allowed to enter the operating theatre area, to ensure compliance with the prevailing Queensland Health policies in respect of surgical safety and clinical risk management.

In accordance with the prevailing Queensland Health policies relating to indemnity ³⁷, health practitioners notify the relevant Health Service Administrator of all incidents, as soon as practicable, where healthcare has been provided without valid informed consent. This excludes limited circumstances such as emergency healthcare to adult patients who do not have capacity (refer to [section 2.3 What situations are there where consent may not be needed](#)

36. *Consent to Treatment Policy for the Western Australian Health System* Second Edition – May 2009 (amended February 2010) p23, Department of Health Western Australia [Online: accessed 16 November 2011] www.safetyandquality.health.wa.gov.au/involving_patient/informed_consent.cfm

37. At the time of publication, these are Indemnity for Queensland Health Medical Practitioners Human Resources Policy I2 (2009) and Indemnity for Queensland Health Employees and Other Persons Human Resources Policy I3 (2009) [Online: accessed 16 November 2011] <http://www.health.qld.gov.au/ghpolicy/docs/pol/gh-pol-152.pdf>

[to provide healthcare to an adult who lacks capacity?](#)) and urgent and life-saving healthcare to children and young persons (refer to [section 3.2 Informed decision-making for urgent and life-saving healthcare to children and young persons](#)). All consent breaches are to be lodged in Queensland Health Clinical Incident Management System (PRIME CI) and the incident is to be managed as per the Queensland Health Clinical Incident Management Policy.

Also, as a component of the clinical risk management program, the healthcare facility should undertake, as a minimum, an annual audit to measure compliance with the informed decision-making process and the implementation standard. The Informed Decision-making in Healthcare Implementation Standard includes a sample of a Procedural Consent Form Audit Tool to meet this clinical governance performance indicator.

Queensland Health requires that as part of the appointment/induction process, a copy of the Informed Decision-making in Healthcare Policy, Implementation Standard and this guide be given to all health practitioners at commencement of employment or contract.

Part 2 Informed decision-making and consent for adults who lack capacity to make decisions ³⁸

As a general principle, even where informed consent from a patient is not required or possible, it is still good practice to explain and involve the patient as much as possible in decisions about their healthcare, using language or other means appropriate to their needs and level of understanding.

Depending on the degree of clinical urgency and availability of substitute decision-makers, the health practitioner should take reasonable steps to obtain consent if practicable, and document these steps in the patient's clinical record.

2.1 What is different for adults who lack capacity to make informed decisions?

A careful assessment of the adult's capacity should be undertaken to confirm the patient does not have capacity to consent to a specific form of healthcare at a specific time as described in [section 1.7 Is this adult patient able to make a decision about healthcare themselves?](#)

In most circumstances where patients lack capacity to make a decision about healthcare themselves, it is necessary to obtain consent from a substitute decision-maker before providing healthcare. However consent may not be required for such patients in relation to:

- a situation where the clinical urgency justifies proceeding without it
- the provision of first aid, a non-intrusive diagnostic examination or administration of a non-prescription drug ³⁹.

2.2 Who can consent for adult patients who lack capacity to make a decision about healthcare? (Substitute decision-makers)

If an adult patient lacks capacity to make a decision about healthcare, the first step is to ascertain if they have previously made an Advance Health Directive about the specific circumstances that arose at a time when they had capacity to do so. Refer to [section 2.2.1 What are Advance Health Directives and when do they apply?](#)

If there is no valid Advance Health Directive, a decision should be sought from a substitute decision-maker in the following order of priority ⁴⁰:

- one or more guardians appointed by the [Queensland Civil and Administrative Tribunal](#) or an Order of the Tribunal.
- one or more attorneys appointed by the patient to deal with the matter in an Enduring Power of Attorney or Advance Health Directive; in circumstances where there is more than one enduring document, the most recent one is to be followed
- a statutory health attorney: the first person from the following list (in descending order of priority) who is readily available and culturally appropriate to make a decision for the matter ⁴¹:
 - a spouse of the adult patient if the relationship is close and continuing

38. This section is based on current *Guardianship and Administration Act 2000* (Qld) which is under review by the Health and Disabilities Committee of Queensland Parliament at time of publication.

39. *Guardianship and Administration Act 2000* (Qld) s63 - 67

40. *Guardianship and Administration Act 2000* (Qld) s66

41. *Powers of Attorney Act 1998* (Qld) s62 - 63

- a person who is 18 years or over and who has the care of the adult patient (but not a paid carer for the adult); this includes someone who provides or arranges domestic services and support to the adult; where a patient resides in an institution, the patient remains in the care of the person in whose care they were immediately before residing in the institution
- a person who is 18 years or over and who is a close friend or relation of the adult patient and is not a paid carer for the adult
- if no other substitute decision-maker is readily available and culturally appropriate to exercise power for a matter, the [Adult Guardian](#).

2.2.1 What are Advance Health Directives and when do they apply?

For further detailed discussion about Advance Health Care Directives, refer to the Queensland Health Withholding and Withdrawing Life-Sustaining Measures Policy and additional Implementation Guidelines accessible through the Clinical Policy Unit Ethics Team website at <http://qhps.health.qld.gov.au/policybranch/html/ethicsteam.htm>. [Intranet Queensland Health staff only.]

In particular refer to section 3.2 ‘Advance Health Directives’ of the ‘*End-of-life care: Decision-making for withholding and withdrawing life-sustaining measures from adult patients – Implementation Guidelines – Part 1*’ <http://qhps.health.qld.gov.au/policybranch/docs/lsmguide1.pdf> [Intranet Queensland Health staff only.]

A valid Advance Health Directive is a document written at a time when an adult patient has capacity to make decisions, and which is intended to act as their substitute decision-maker at a later time when they no longer have such capacity ⁴².

Since the effect of the document is of the patient making healthcare decisions while they had capacity, they are entitled to consent to or withhold healthcare. However, where the decision relates to declining of life-sustaining measures, certain conditions need to be met. These are detailed in section 3.2 of the End-of-life care: Decision-making for withholding and withdrawing life-sustaining measures from adult patients – Implementation Guidelines – Part 1.

A valid Advance Health Directive is respected and followed and takes precedence over healthcare requests made by family members or substitute decision-makers. However, an Advance Health Directive is not applicable where the patient has or regains capacity.

Advance Health Directives do not have a time limit and may be revoked in writing at any time, as long as the patient has capacity to do so. However, it is recommended the document be reviewed every two years or if the person’s health changes significantly ⁴³.

The following is quoted directly from the End-of-life care: Decision-making for withholding and withdrawing life-sustaining measures from adult patients - Implementation Guidelines - Part 1 and highlights the complexity and resultant difficulties that may arise in relation to whether an Advance Health Directive is valid.

3.2.2 Consent under an Advance Health Directive

An Advance Health Directive is a legally recognised expression of the patient’s wishes in relation to future health care decisions. An Advance Health Directive must be:

1. *A written document; and*
2. *Signed by the adult patient (or by an ‘eligible signer’ ⁴⁴ on the adult’s behalf); and*

42. Powers of Attorney Act 1998 (Qld) s35 - 40

43. ‘Changing or revoking an advance health directive’ Queensland Department of Justice and Attorney-General [Online: accessed 16 November 2011] www.justice.qld.gov.au/justice-services/guardianship/making-health-care-decisions/advance-health-directives/changing-or-revoking-a-directive

44. For definition of ‘eligible signer’ see Powers of Attorney Act 1998 (Qld) s30.

3. Signed and dated by an 'eligible witness'⁴⁵ and certified that the document was signed in their presence and the adult appeared to them to have capacity; and
4. Signed and dated by a medical officer (not the witness) and certified that the adult appeared to the medical officer to have capacity to make the Advance Health Directive.

The health care team is entitled to sight the original or certified copy of the Advance Health Directive. It is the responsibility of the person making an Advance Health Directive to make sure the decisions in their document will be drawn to the attention of health care professionals when it is needed at a future time. Certified copies of the Advance Health Directive may be held at the hospital where the patient is being treated, in the medical records of the patient's general practitioner, in the possession of a close relative, or at the person's own residence. Some people may also carry a card or wear a bracelet with information to this effect.

An Advance Health Directive is not applicable in the situation where the patient has or regains capacity. If a patient regains capacity, if they wish, they can revoke previous directions.

An Advance Health Directive should not be relied upon in any of the following circumstances:

- if the document is obviously defective (such as pages missing, not signed, dated or witnessed)
- if there is doubt about the directions themselves (for example, terminology or treatment pathology)
- if the directions are uncertain or inconsistent with good medical practice
- if the proposed treatment is not the treatment specified in the Advance Health Directive
- if the circumstances are different from those that have been set out in the advance decision
- if the person withdrew the decision while they still had capacity to do so
- if personal or medical circumstances have changed to the extent that the direction to withhold or withdraw life-sustaining measures is no longer appropriate
- if the person has done something that clearly goes against the advance decision which suggests they have changed their mind.

It is also important to establish that the person making the Advance Health Directive was 18 or older when they made their decision and that they had capacity to do so.

If the Advance Health Directive is deemed not to be valid, the statutory consent process must be followed, that is, using the patient's substitute decision-maker/s. [Refer to [Who can consent for adult patients who lack capacity to make a decision to consent to healthcare or not? \(Substitute decision-makers\)](#)]

If it is established that the Advance Health Directive is valid, the directions must not only be respected, but followed⁴⁶, as it is a legally binding document, acting as the patient's decision-maker/s when they lose capacity. Since the effect of the document is of the adult patient making health care decisions while they had capacity, they are entitled to refuse any

45. For definition of 'eligible witness' see *Powers of Attorney Act 1998* (Qld) s31.

46. Note that there are some exceptional situations where medical officers can choose not to follow the directions in an Advance Health Directive. Refer to the [section 2.3 'Deciding not to follow an Advance Health Directive'](#) of the quoted text for more detail.

medical treatment. Legally, valid Advance Health Directives take precedence over treatment requests made on behalf of the patient by family members.

The treating medical team must always start from the assumption that the person had the capacity to make the advance decision, but even in emergency situations, as far as practicably possible, medical staff must ensure that the Advance Health Directive is a valid document.

To be applicable, directions in an Advance Health Directive must apply to the situation in question and in the current circumstances. However it should be noted that objections to certain forms of treatment can be made at a previous time, and must also be taken into consideration in the decision-making process. Health care professionals must first determine if the person still has capacity to accept or refuse treatment at the relevant time. If they have capacity, they can refuse treatment at this point, or they can change their decision and accept treatment. In deciding whether an advance decision applies to the proposed treatment, the medical officer responsible for the patient's care must consider:

- the date of the Advance Health Directive, the patient's clinical circumstances and whether the advance decisions relate to those circumstances, and
- whether there have been any changes in the patient's personal life (for example, the person is pregnant and this was not anticipated at the time of the advance decision) that might affect the validity of the advance decision, and
- whether there have been any developments in medical treatment that the person did not foresee (for example, new medications, treatment or therapies), and
- if any prior objections to health treatment have been made in any capacity. These objections must be taken into consideration in all decision-making about providing or not providing medical treatment, and
- whether a patient may have included in their Advance Health Directive that they consent to withholding or withdrawal of life-sustaining measures despite the objection at the time this is occurring. This must be respected.

Note also that under the legislation⁴⁷ Advance Health Directives do not have a time limit despite the recommendation on the prescribed form⁴⁸ the document should be reviewed every two years. Revoking an Advance Health Directive 'may' be done in writing while the person still has capacity. There is no specific or prescribed form for revoking an Advance Health Directive as there is for an Enduring Power of Attorney.

It is Queensland Health's policy that certified copies of Advance Health Directives are permitted in certain circumstances. Clinical and administrative personnel may certify a photocopy or facsimile of an original Advance Health Directive to keep on the patient's records. This may also be useful when transferring patients between facilities. However it should be recognised that this does carry an element of risk. For example, the patient may revoke the copied Advance Health Directive and make a new one some months later and neglect to inform the hospital when they are admitted. Despite this, it is acknowledged that in many circumstances when immediate decisions are required, file copies of Advance Health Directives may be the best indication of a patient's wishes. Even if the Advance Health Directive later proves to be 'invalid', it would still comply with common law evidentiary provisions.

47. Powers of Attorney Act 1998 (Qld) s35 -40

48. 'Changing or revoking an advance health directive' Queensland Department of Justice and Attorney-General [Online: accessed 16 November 2011] www.justice.qld.gov.au/justice-services/guardianship/making-health-care-decisions/advance-health-directives/changing-or-revoking-a-directive

3.2.3 Deciding not to follow an Advance Health Directive

If, after careful consideration, a medical officer chooses not to follow a patient's Advance Health Directive⁴⁹, a second opinion must be sought from another senior medical officer or consultant. Meticulous and thorough record-keeping will be required in these circumstances. Utmost care should be taken in this area because, while the law does offer some protections for not following the directions in a valid Advance Health Directive⁵⁰, there are risks if medical officers choose not to do so.

Generally, medical officers are protected in circumstances where:

- they act in reliance on an Advance Health Directive without knowledge of its invalidity, or*
- they act without knowledge of the existence of an Advance Health Directive, or*
- they fail to act in accordance with an Advance Health Directive that is uncertain, inconsistent with good medical practice or that they otherwise consider is inappropriate due to circumstances changing since the directive was made. [However, the health practitioner is expected to consult with any attorney appointed under the advance health directive, where they believe a direction in the advance health directive is uncertain⁵¹.]*

However, the onus of proof of 'uncertainty' would be on the medical officer who may be required to defend this position in a court of law. Therefore the need to clearly document these circumstances cannot be overstated.

If there is any doubt about whether an Advance Health Directive is valid, it is recommended legal advice be obtained. However, in an emergency where health practitioners have taken all reasonable steps to assess the situation and are unable to obtain appropriate legal advice within the context of the clinical urgency, they should err on the side of preserving life or limb function, keep meticulous clinical records and be prepared to justify their decision.

2.2.2 Advance Health Directives and children

The Powers of Attorney Act 1998 (Qld) specifies that to make an Advance Health Directive, the patient must be a competent adult (that is, 18 years of age). This means a child or young person is not able to make an Advance Health Directive under the Queensland legislation. However, this appears inconsistent with the principle that where a child or young person is mature enough to have sufficient capacity to understand all the issues, they can consent on their own.

It would seem logical that if a child or young person had sufficient capacity to decide an issue, the Australian Court would support that decision⁵². However, at present, the law in this area has not been adequately tested in Australia, and so a health practitioner should obtain legal advice on a case-by-case basis as to the validity of an Advance Health Directive given by a person under the age of 18 years.

The strength of the evidence of the child or young person's capacity on a particular issue would depend on the significance of the decision being made. A child or young person's decision to decline or withdraw consent to life-sustaining treatment would require a significant degree of maturity to the same level as an adult making such a decision.

49. This would include whether the document is an original document, rather than a photocopy or facsimile.

50. Section 103 of the *Powers of Attorney Act 1998* permits medical officers to override directions in an Advance Health Directive if the directions are inconsistent with good medical practice. This particular section offers statutory protection for such decisions.

51. Section 103 of the *Powers of Attorney Act 1998*

52. Willmott, Lindy (2007), *Advance directives to withhold life-sustaining medical treatment: eroding autonomy through statutory reform*, *Flinders Journal of Law Reform*, 10(2). pp. 287-314. [Online: accessed 16 November 2011] <http://eprints.qut.edu.au/19152/2/19152.pdf>

2.3 What situations are there where consent may not be needed to provide healthcare to an adult who lacks capacity?

2.3.1 Healthcare without significant risk for adult patients who lack capacity to consent

Where patients lack capacity to decide for themselves, health practitioners can (and may have an obligation to) provide first aid and carry out a non-intrusive examination for diagnostic purposes (including a visual examination of an adult's mouth, throat, nasal cavity, eyes or ears) ⁵³ without consent if it is otherwise in the patient's best interests.

In addition, healthcare without significant risk to the patient can be carried out without consent from a patient who lacks capacity ⁵⁴ or a substitute decision-maker if:

- it is necessary to promote the adult's health and wellbeing and
- it is of the type that best promotes the adult's health and wellbeing.

Examples of such healthcare include administering an antibiotic requiring a prescription, or administering a tetanus injection.

To act within the Queensland legislation ⁵⁵ the health practitioner needs to be able to demonstrate that given the circumstances they have taken reasonable steps to:

- confirm the adult patient has impaired capacity for the specific matter at that particular time
- confirm the adult patient has impaired capacity for the specific matter at that particular time
- establish the adult patient does not object, or has not previously objected to the healthcare ⁵⁶
- obtain a decision, and/or find out about previous decisions, from a substitute decision-maker
- find out about and consider any dispute among individuals the health practitioner reasonably considers have a sufficient and continuing interest in the adult about:
 - the carrying out of the healthcare
 - the capacity of the adult to understand the health matter.

The health practitioner is required to certify (document fully, including any reasons) in the patient's clinical records the details of each of the criteria under which they have provided the healthcare.

2.3.2 Urgent healthcare for adult patients who do not have capacity to consent

The *Guardianship and Administration Act 2000* (Qld) permits 'urgent healthcare' to be provided without consent from the patient or a substitute decision-maker when a health practitioner reasonably considers the patient lacks the capacity to decide, and the healthcare needs to be carried out urgently to:

- meet imminent risk to the adult's life or health or
- prevent significant pain or distress ⁵⁷.

53. The Schedule 2 dictionary of the *Guardianship and Administration Act 2000* (Qld) explicitly defines these as not being 'health care'.

54. *Guardianship and Administration Act 2000* (Qld) s64

55. *Guardianship and Administration Act 2000* (Qld) s64

56. The Schedule 4 Dictionary of the *Guardianship and Administration Act 2000* (Qld) states:

'object, by an adult, to health care means:

(a) the adult indicates the adult does not wish to have the health care

(b) the adult previously indicated, in similar circumstances, the adult did not then wish to have the health care and since then the adult has not indicated otherwise.

Example: An indication may be given in an Enduring Power of Attorney or Advance Health Directive or in another way, including, for example, orally or by conduct.'

57. *Guardianship and Administration Act 2000* (Qld) s63

For more details on the criteria relating to these situations refer to the following sections of this guide.

It is important to note this includes providing life-sustaining measures. For the withholding or withdrawal of a life-sustaining measure in an acute emergency for an adult who lacks capacity, refer to [section 2.3.5 The withholding and withdrawing of life-sustaining measures in an acute emergency from adult patients who lack capacity to consent](#).

A life-sustaining measure in this context is one that is intended to sustain or prolong life and which supplants or maintains the operation of vital bodily functions that are temporarily or permanently incapable of independent operation⁵⁸. This includes:

- cardiopulmonary resuscitation
- assisted ventilation
- artificial nutrition and hydration.

A blood transfusion is not a life-sustaining measure.

2.3.3 Healthcare required urgently to meet imminent risk to the adult's life or health

A health practitioner may provide urgent healthcare to an adult patient without consent where they reasonably consider:

- the healthcare needs to be carried out urgently to meet an imminent risk to the patient's life or health
- the adult patient lacks the capacity to make a decision
- the health practitioner has taken reasonable steps (given the clinical circumstances) to establish:
 - at the time of the healthcare being provided whether the adult patient has impaired capacity for the specific health matter
 - the patient has not objected in an Advance Health Directive.

By law⁵⁹, the health practitioner is required to certify (document fully, including any reasons) in the patient's clinical records the details of each of the criteria under which they have provided the urgent healthcare. The health practitioner documents in the patient's clinical records the circumstances (including any reasons) under which they have provided the healthcare.

2.3.4 Healthcare required urgently to prevent significant pain or distress

A health practitioner may provide urgent healthcare to an adult patient without consent where they reasonably consider:

- the healthcare needs to be carried out urgently to prevent significant pain or distress
- it is not reasonably practical to get consent from a substitute decision-maker (refer to [section 2.2 Who can consent for adult patients who lack capacity to make a decision about healthcare? \(Substitute decision-makers\)](#))
- where the adult objects:
 - the healthcare is likely to cause the adult either no distress, or temporary distress that is outweighed by the benefit to the adult of the healthcare⁶⁰
 - the adult patient has minimal or no understanding of what the healthcare involves and/or why it is required.

58. *Guardianship and Administration Act 2000* (Qld) Schedule 2 s5A

59. *Guardianship and Administration Act 2000* (Qld) s63(4)

60. *Guardianship and Administration Act 2000* (Qld) s63

By law ⁶¹, the health practitioner is required to certify (document fully, including any reasons or relevant circumstances) in the patient's clinical records the details of each of the criteria under which they have provided the urgent healthcare.

For more information see s63 of the *Guardianship and Administration Act 2000* (Qld). Visit www.legislation.qld.gov.au/LEGISLTN/CURRENT/G/GuardAdminAoo.pdf [Online: accessed 16 November 2011]

2.3.5 The withholding and withdrawing of life-sustaining measures in an acute emergency from adult patients who lack capacity to consent

It is paramount to recognise there is a difference between providing life-sustaining healthcare and withholding or withdrawing of such measures.

In an acute emergency, such as when cardiopulmonary resuscitation (CPR) is required, consent is not required to provide urgent life-sustaining healthcare to an adult patient who does not have capacity to make a decision, as long as the health practitioner is not aware of any objections to the healthcare by the patient, for example through an Advance Health Directive.

In an acute emergency, a life-sustaining measure may be withheld or withdrawn for an adult without consent if the medical practitioner responsible for a patient reasonably considers:

- the adult has impaired capacity for the health matter concerned
- the commencement or continuation of the measure for the adult would be inconsistent with good medical practice
- the decision to withhold or withdraw the measure is taken immediately, consistent with good medical practice ⁶².

However, artificial nutrition and hydration may not be withheld or withdrawn in acute circumstances ⁶³ such as a stroke or myocardial infarct.

The medical practitioner has the necessary skills, knowledge and experience to make an assessment whether the decision is consistent with good medical practice.

Health practitioners who are not medical practitioners are not able to make the decision to withhold or withdraw life-sustaining measures in an acute emergency from an adult patient who lacks capacity to consent.

The measure may not be withheld or withdrawn without consent if the medical practitioner knows the adult objects to the withholding or withdrawal. An objection might be when the patient requests the medical practitioner to 'Do everything possible' or communicates the message 'Don't let me die' before losing capacity. Under these circumstances consent from the patient's substitute decision-maker/s would be required if the clinical decision is not to provide healthcare.

By law ⁶⁴, the medical practitioner is required to certify (document fully) in the adult's clinical records as to the various considerations enabling the measure to be withheld or withdrawn. This includes documenting any advance health directive, or discussions with substitute decision-makers, other steps taken and the reasons behind any decision. This might include:

- explanations or evidence as to why providing life-sustaining measures would be inconsistent with good medical practice
- why the decision to withhold or withdraw is taken immediately, consistent with good medical practice.

61. *Guardianship and Administration Act 2000* (Qld) s63(4)

62. *Guardianship and Administration Act 2000* (Qld) s63A

63. *Guardianship and Administration Act 2000* (Qld) s63A(4)

64. *Guardianship and Administration Act 2000* (Qld) s66B

In a situation where an advance health directive exists which indicates a patient's wishes to withhold or withdraw a life-sustaining measure, the advance health directive can not operate unless the patient:

- has a terminal illness or condition that is incurable or irreversible and as a result of which, in the opinion of a medical practitioner treating the patient and another medical practitioner, the patient may reasonably be expected to die within one year
- is in a persistent vegetative state (that is, has a condition involving severe and irreversible brain damage but some or all of the patient's vital functions continue, including for example, heart beat or breathing)
- is permanently unconscious or in a coma (that is, has a condition involving brain damage so severe there is no reasonable prospect of them regaining consciousness)
- has an illness or injury of such severity there is no reasonable prospect they will recover to the extent that their life can be sustained without the continued application of life-sustaining measures
- has no reasonable prospect of regaining capacity to make decisions about healthcare ⁶⁵.

2.3.6 Artificial nutrition and/or hydration

Where a patient has capacity to decide, consent is required before the initiation, withholding or withdrawal of artificial nutrition and/or hydration.

Where a patient lacks capacity to decide, artificial nutrition and/or hydration may be initiated without consent when it is:

- necessary to meet imminent risk to the adult's life or health; or
- required urgently to prevent significant pain or distress.

Artificial nutrition and/or hydration may not be withheld or withdrawn without consent, even as an urgent decision, and consent is obtained to withhold or withdraw artificial hydration and/or nutrition.

In other situations where a patient lacks capacity to decide for themselves, informed consent to withhold or withdraw artificial nutrition and/or hydration is to be provided by the substitute decision-maker.

Where a patient has given an Advance Health Direction to withhold or withdraw artificial nutrition or artificial hydration, the direction is only valid if the commencement or continuation of the measure would be inconsistent with good medical practice ⁶⁶. See also [sections 2.2.1 What are Advanced Health Directives and when do they apply?](#) and [2.3.5 The withholding and withdrawing of life-sustaining measures in an acute emergency from adult patients who lack capacity to consent.](#)

For further detailed discussion about 'End-of-life care: Decision-making for withholding and withdrawing life-sustaining measures from adult patients', refer to the Queensland Health Policy and additional Implementation Guidelines accessible through the Clinical Policy Unit Ethics Team website at <http://qheps.health.qld.gov.au/policybranch/html/ethicsteam.htm> [Intranet Queensland Health staff only.]

2.3.7 Can the use of force (including physical restraint and sedation) be justified when providing healthcare to adult patients who lack capacity to make a decision?

The use of force including physical or chemical restraint (sedation) on a patient receiving health services is a very serious matter.

65. Powers of Attorney Act 1998 (Qld) s36

66. Guardianship and Administration Act 2000 (Qld) s36

While recognising that the use of force is a component of healthcare, Queensland Health expects it would be implemented only:

- when other alternatives to minimise harm to the patient and others, or to optimise patient outcomes, have been considered and are inappropriate or ineffective
- when the benefits clearly outweigh any distress (even temporary) that might be caused to the patient
- in accordance with:
 - good clinical practice
 - relevant behaviour management training policy
 - other relevant endorsed clinical policies
- in accordance with legal requirements under the:
 - *Mental Health Act 2000* (Qld)
 - *Powers of Attorney Act 1998* (Qld)
 - *Guardianship and Administration Act 2000* (Qld)
 - *Disability Services Act 2006*
 - *Forensic Disability Bill 2011*
 - *Criminal Code Act 1899* (Qld)
 - any other relevant law.
- when appropriate safety measures are implemented
- when a patient has the capacity to provide consent and they have done so
- where a patient lacks the capacity to consent, such consent has been provided by an appropriate substitute decision-maker, or the healthcare is in accordance with the legal requirements above
- for patients requiring repeated intervention for challenging behaviours, in accordance with a behaviour support plan developed by the treating team.
- details as to the circumstances of and the reasons for implementing the restraint are to be documented in the patient's clinical record and an appropriate incident report lodged in accordance with Queensland Health policy⁶⁷.

For patients of an authorised mental health service, the use of force or restraint is carried out as defined in the *Mental Health Act 2000* (Qld) and in accordance with the Queensland Health policy statement on reducing and where possible eliminating restraint and seclusion in Queensland mental health services . Visit www.health.qld.gov.au/mentalhealth/docs/sandrpolicy_081030.pdf. [Online: accessed 16 November]

For other patients who do not have capacity to consent or decline consent, the use of restraint may be authorised under the *Guardianship and Administration Act 2000* (Qld) where:

- the restraint constitutes 'healthcare',⁶⁸ that is, where the practice, as a treatment, has a therapeutic effect upon a patient's physical or mental condition; and should be carried out urgently to:
 - *meet imminent risk to the adult's life or health; or*
 - *should be carried out urgently to prevent significant pain or distress to the adult and it is not reasonably practical to get consent from a person who may give it under the Guardianship and Administration Act 2000 (Qld) or the Powers of Attorney Act 1998 (Qld)*

67. Adapted from RBWHS policy 88358/Proc: Physical Restraint of a Patient (<http://hi.bns.health.qld.gov.au/rbh/policies/procedures/88358proc.pdf>) [Intranet Queensland Health staff only]

68. The *Guardianship and Administration Act 2000* (Qld) definition of healthcare which is care or treatment of the adult (with impaired capacity) (a) to diagnose, maintain or treat the adult's physical or mental condition and (b) carried out by, or under the direction or supervision of a health provider.

- the other requirements of the Act relating to providing healthcare to a person who lacks capacity, are satisfied. This effectively means that either the requirements of section 63 of the Act in relation to urgent healthcare are met (refer to [section 2.3.2 Urgent healthcare for adult patients who do not have capacity to consent](#)), or the consent of a relevant substitute decision-maker is obtained to the restraint.

In addition, a health provider ⁶⁹ and a person acting under the health provider's direction or supervision may use the minimum force necessary and reasonable to carry out healthcare authorised under the Act ⁷⁰.

Except in an acute emergency, therefore, before using force or restraint, the health practitioner ensures reasonable steps are taken to obtain consent from substitute decision-makers and to seek the views of those the health practitioner reasonably considers to have a sufficient and continuing interest in the adult. Where there is doubt or disagreement, it is recommended that legal advice be sought.

Health practitioners need to be aware that the use of force on a patient may lead to civil, criminal, disciplinary or professional conduct investigations against them, and their reasons may not be accepted as being justified unless their actions clearly accord with relevant professional, policy and legal requirements. If in doubt, it is recommended that health practitioners seek guidance from a senior health practitioner, and/or obtain legal advice. Queensland Health staff members are advised to implement any policy on the use of restraint on patients that might be issued in the future.

2.3.8 Is there healthcare that cannot be provided to adult patients who lack capacity to make decisions for themselves?

In addition to healthcare that is illegal in general (refer [section 2.4 Is there healthcare which is prohibited completely or which is prohibited unless certain requirements are met?](#)), the following types of special healthcare require the consent of the Queensland Civil and Administrative Tribunal (QCAT) or other appropriate tribunal to be provided to an adult without the capacity to make a decision ⁷¹:

- removal of tissue from an adult while alive for donation to someone else
- sterilisation of an adult (although infertility as a consequence of treating an organic disease or malfunction is not included)
- termination of a pregnancy in an adult
- participation by an adult in special medical research or experimental healthcare
- electroconvulsive therapy or psychosurgery for an adult ⁷²
- special healthcare of an adult that may be restricted under future legislation.

2.4 Is there healthcare which is prohibited completely or prohibited unless certain requirements are met?

There are some forms of healthcare which are prohibited by law, for example:

- female genital mutilation ⁷³
- non-regenerative tissue removal from a child for donation purposes ⁷⁴.

69. *Guardianship and Administration Act 2000* (Qld) Schedule 4 - defines health provider as a person who provides health care or special health care in the practice of a profession or the ordinary course of business

70. *Guardianship and Administration Act 2000* (Qld) s75

71. *Guardianship and Administration Act 2000* (Qld) s68-74

72. *Mental Health Act 2000* (Qld) s139 and s161

73. *Criminal Code Act 1899* s323A

74. *Transplantation and Anatomy Act 1979*

There are also some forms of healthcare prohibited by law unless certain specific legal requirements are met, for example:

- termination of pregnancy ⁷⁵
- regenerative tissue removal from a child for donation purposes ⁷⁶
- removal of blood from a child for transfusion or therapeutic purposes ⁷⁷
- sterilisation of a child with impairment ⁷⁸.

These issues are not dealt with further in this guide and the reader is referred to the original legislation.

75. *Criminal Code Act 1899* s224 –226

76. *Transplantation and Anatomy Act 1979* s12B

77. *Transplantation and Anatomy Act 1979* s18

78. *Guardianship and Administration Act 2000* (Qld) Chapter 5A - 'Impairment' means a cognitive, intellectual, neurological, or psychiatric impairment.

Part 3 Informed decision-making and consent for children and young persons

In Queensland, anyone under the age of 18 is considered a ‘minor’. For consistency, within this guide the term ‘children or young persons’ is used to describe patients from birth until their 18th birthday.

References to ‘children’ usually mean younger children who are likely to lack the maturity and understanding to make important decisions for themselves. Older or more mature children who may have capacity to make decisions about healthcare are referred to as ‘young persons’.

3.1.1 At what age can children and young persons consent for themselves?

When a child or young person under the age of 18 years does not have capacity to consent, consent is obtained from a parent or other person with parental responsibility⁷⁹ except in specific situations. Persons with parental responsibility have a responsibility to consent to healthcare that is in the best interests of the child or young person.

Children and young persons under the age of 18 years are able to consent to healthcare where they have sufficient capacity to do so. However, unlike adults, a child or young person is presumed not to have capacity to give their own consent, unless there is sufficient evidence they have such capacity. This is often referred to as ‘Gillick competence’ after a legal case in the United Kingdom⁸⁰. (Refer to section [3.1.5 How to assess whether a child or young person is ‘Gillick competent’ and has capacity to give consent to healthcare?](#))

In Queensland there is no fixed lower limit below 18 years of age at which children or young persons are deemed to be able to consent to healthcare, and so, as they mature, the child’s capacity to consent generally increases. On the other hand, the authority of parents to consent on behalf of a child or young person is not absolute. Their parental responsibility decreases as the young person matures until it ceases to exist when the child reaches 18 years of age. As a result of this there may be times when both someone with parental responsibility and the child or young person simultaneously have the ability to provide consent to healthcare.

If the child or young person has sufficient capacity to consent and does so, this is usually sufficient for giving routine medical/dental treatment, including contraceptive advice, without the need for parental consent. However, even though a child or young person may have capacity to consent on their own, it is good practice to encourage them to consider seeking the involvement of a parent or other adult of their choosing before reaching a decision. This may:

- provide the adult with appropriate information (including any necessary supervision arrangements and of possible adverse effects) so they might support the young person in their decision and during the healthcare
- give the adult the opportunity to provide information that the young person may not be aware of (for example, details of previous medical conditions and relevant family history) and to have questions answered in advance
- allow the adult the opportunity to attend when the healthcare (for example, immunisation) is provided with the agreement of the patient.

If a child or young person does not wish to involve a parent or other adult, the reasons for this are explored.

If the child or young person has sufficient capacity to make a decision not to involve an adult, their wishes usually need to be respected, but may be overruled in some circumstances, for example, when there are potential child protection concerns arising from a pregnancy or a sexually transmitted infection. A medical practitioner or registered nurse who becomes aware, or reasonably suspects during the practice of his or her profession, that a child has been, is being or is likely to be harmed⁸¹, is required by law to report child protection concerns. Visit the

79. *Family Law Act 1975*, Part VII, Division 2, Section 61A-61F

80. *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112 (HL) House of Lords (England)

81. *Public Health Act 2005*, section 191 and 192

Child Safety Services website: www.communities.qld.gov.au/childsafety/child-safety-services[Online: accessed 16 November 2011]. Other health practitioners who have similar concerns arising from their professional involvement with children should seek advice on any obligation to report their concerns.

3.1.2 Who can consent for a child or young person?

The child or young person

When the child or young person is sufficiently mature to have capacity to consent to the particular healthcare, they are able to do so. The terms ‘Gillick competent’ and ‘mature minors’ are sometimes used to describe this group of patients.

Parents ⁸²

Each parent has full parental responsibility for a child or young person unless this is altered by a court order. Consent from one parent alone is sufficient, but where there is significant risk to the patient, it may be prudent to seek consent from both parents. In cases where there is a strongly opposing view, or there is disagreement from the other parent, legal advice may be required.

Separated or divorced parents still retain equal parental responsibility unless the court orders otherwise. When the court has made such orders, consent is to be obtained in accordance with that order. Court orders should be sighted by the healthcare professional before separated or divorced parents need to consent to their child receiving healthcare.

Adoptive or surrogacy ⁸³ parents have the same parental rights and responsibilities in relation to a child or young person as if they were the child or young person’s natural parent ⁸⁴.

Step-parents and de facto partners do not have legal authority to give consent unless they are an adoptive parent or legal guardian.

Parents who are themselves under 18 years old

Queensland Health endorses the following approach:

- If the parent is deemed by the medical practitioner to have sufficient capacity, any consent given by the parent on behalf of their child would be considered valid.
- If the medical practitioner finds the parent not to have sufficient capacity to decide, the Department of Communities (Child Safety) should be contacted to appoint a legal guardian to make decisions on behalf of the child and ensure decisions are made in the child’s best interests.
- If the suggested healthcare carries significant risk, and/or the parent objects to the healthcare proposed, an application to the Supreme Court should be considered. Although applications can be made outside of normal working hours and on short notice the entire legal process may take some time. Prior to completion of the process, and subject to legal advice, the health practitioner proceeds, as in [section 3.2 Informed decision-making for urgent and life-saving healthcare to children and young persons](#), and can provide healthcare without consent where it is urgent or life-saving and in the best interests of the child or young person.

A person granted guardianship of the child

A person granted guardianship of the child, for example under a child protection order made under the *Child Protection Act 1999* ⁸⁵ or *Adoption Act 2009* ⁸⁶, has the same rights and responsibilities as a natural parent in relation to consent.

82. *Family Law Act 1975* Part VII, Division 2, Section 61A-61F

83. *Surrogacy Act 2010*

84. *Adoption Act 2009* s13 and Schedule 1

85. *Child Protection Act 1999* (Qld) s13

86. *Adoption Act 2009* (Qld) s13

Grandparents, other relatives or care-givers

Grandparents, other relatives or care-givers apart from parents should produce evidence of a court order, or demonstrate the existence of another legal relationship (for example, testamentary guardianship) to be able to consent to healthcare on behalf of a child or young person.

The Supreme Court of Queensland or the Family Court

The Supreme Court of Queensland can exercise its role as the supreme parent of children⁸⁷. The Family Court of Australia has a similar authority⁸⁸.

An application to the court should be considered in situations, and with procedures, that are so serious that neither young person, parent nor guardian can give valid consent. This includes situations where:

- the procedure is very high risk (for example, separating conjoined twins)
- there may be life changing effects (for example, sterilisation of mentally disabled young persons, abortions, removal of life support, the removal of organs for transplants, gender re-assignment and bone marrow harvest)
- there is a strong objection from a dissenting parent
- a child with capacity to make decisions is refusing healthcare and there is significant risk of harm in them doing so
- the procedure involves invasive, irreversible or major surgery (excluding lifesaving emergency surgery).

The court would consider the best interests of the child as the paramount consideration.

If there is any doubt in relation to consent to provide healthcare to a child or young person, it is strongly recommended that legal advice is obtained. If necessary, applications to the court can be made after business hours and at short notice. The local Departmental Director or Medical Superintendent will have the contact details of the local District Solicitor.

3.1.3 What about children who are placed in care?

Under the *Child Protection Act 1999*, a person granted ‘guardianship’ of a child under a protection order has the equivalent right and responsibility of someone with parental responsibility to make decisions about the daily care, long-term care, well-being and development of the child. This would include decisions about their healthcare⁸⁹. Generally, long-term care decisions are those about issues likely to have a significant or long-term impact on the child’s development.

An order granting guardianship may be made by the court in favour of the Chief Executive of the Department of Communities (Child Safety) or a suitable person, including a member of the child’s family⁹⁰. Sometimes, parents retain guardianship of the child while the Chief Executive or another suitable person is granted custody.

‘Custody’ is more limited than guardianship, and is restricted to the right to have the child’s daily care and the right and responsibility to make decisions about the child’s daily care. Daily care might include managing existing healthcare matters but may not include decisions about future long-term healthcare.

Children placed in out-of-home care may be in the care of formally approved foster carers or kinship carers⁹¹. The nature of the care arrangements under which the child is placed usually determines what authority these carers have to make healthcare decisions, however, generally, these carers are only granted custody rights for the child.

87. *Parrens patriae jurisdiction*

88. *Family Law Act (Cwth) 1975 s67ZC (1)*

89. *Child Protection Act 1999 (Qld) s13*

90. *Family Law Act (Cwth) 1975 s61(f)*

91. *Child Protection Act 1999 (Qld) s82*

One of the key issues for health practitioners is to establish the authority of any person who is not the parent presenting with a child for healthcare. It would be advisable to liaise with the Department of Communities (Child Safety) regarding the legal status of children and the nature of care arrangements (that is, who has responsibility for daily healthcare and long-term healthcare decisions) (refer to [section 3.1.4 What evidence of the authority to consent to healthcare is required?](#)).

Even where parents do not have current custody of the child, it may still be good clinical practice to involve them in communications about the child's healthcare where it would be in the best interests of the child to do so. Caution needs to be exercised by health professionals here as, in some circumstances, the Department of Communities (Child Safety) would need to authorise the release of such information about children who have been placed in care.

In regard to clinical decision making, the Department of Communities (Child Safety) has published the Child Safety Practice Manual (www.communities.qld.gov.au/childsafety/child-safety-practice-manual) which provides guidance on decision-making about healthcare for children in care ⁹². This includes situations where a child or young person is in the custody of an approved kinship or foster carer, or under the guardianship of the Chief Executive. Queensland Health encourages staff to use the manual as a general guide to help identify which healthcare decisions relate to the child's daily care, and which relate to the child's long-term care, wellbeing and development. However, sometimes it may be difficult to classify whether the healthcare would be viewed as daily care or not, and, in such cases, staff are encouraged to obtain advice from the Department of Communities (Child Safety), Child Safety Service Centre Managers or Regional Directors, or seek legal assistance.

If the child or young person has the capacity to make a decision in respect of the proposed healthcare, then they may be able to provide consent to the treatment in appropriate circumstances and consent from the person having custody or guardianship may not be required (refer to [section 3.1.5 How to assess whether a child or young person is 'Gillick competent' and has capacity to give consent to healthcare?](#)).

The Child Safety Practice Manual outlines the responsibilities a person with custody has in respect to a child's healthcare. These include the responsibility to seek healthcare and dental assistance, including administering prescription medication for established conditions in accordance with an existing treatment regime, administering non-prescription medication and seeking routine medical attention for common illnesses. However, a person with custody may not have the authority to consent to a proposed a new treatment regime or other healthcare or where it would be considered something other than a matter of daily care.

The Child Safety Practice Manual also outlines the responsibilities a person with guardianship has in respect of the child's health care, including matters such as medical examination or treatment (including routine medical care), invasive medical examinations and surgical procedures: The manual states this encompasses:

- *immunisation*
- *blood tests*
- *invasive medical and surgical procedures, examinations or considerations, for example, medical treatment involving general anaesthetic, blood transfusion, surgery, the degree of care to be provided to a critically ill child or decisions in relation to the termination of life support*
- *DNA testing*
- *pregnancy termination*
- *contraception where one of the following applies:*
 - *a child is under 12 years of age*

92. Child Safety Practice Manual, Department of Communities (Child Safety) Queensland Health, November 2010, Chapter 5, Children in out-of-home care, Decision-making for the child 3.6 *Make medical decisions, including dental* [Online: accessed 16 November 2011] www.communities.qld.gov.au/childsafety/child-safety-practice-manual/chapters/5-children-in-out-of-home-care

- *a child is not considered ‘Gillick competent’*
- *the treatment is medium or long-term and/or may have health risks - for example, progesterone implants or Depo-Provera injections*
- *acting on a second medical opinion*
- *the use of prescribed medications to manage behaviour or mental health conditions - for example, dexamphetamines and anti-depressants*
- *end of life decisions - refer to [8. What if a decision about end of life medical treatment is required?](#)*
- *management of smoking behaviour.*

Consent from a person with guardianship of the child under the Act would be required before a more complex or intimate examination, investigation, procedure or treatment, or one with greater risks or consequences, was performed.

Before relying on the consent of a person with rights of custody only (which will generally include an approved foster carer or kinship carer) the health practitioner should be satisfied:

- about the extent of that person’s authority to consent to healthcare
- that the healthcare would reasonably be considered a matter of routine daily care
- that the healthcare (including any examination, investigation or treatment) is non-obtrusive
- that there is no significant risk to the patient and no significant long-term consequences
- that the healthcare (examination or treatment) is necessary to promote the child or young person’s health and wellbeing
- that the healthcare (examination or treatment) is of the type that will best promote the child or young person’s health and wellbeing
- that there is no objection from a person who has guardianship in respect of the child or young person
- that where the child or young person has the capacity to consent to the proposed healthcare, they have done so.

3.1.4 What evidence of the authority to consent to healthcare is required?

Other than in the case of an emergency, or where it has been determined that the consent of the child or young person can be safely relied upon, reasonable attempts are undertaken to establish the identity of the person accompanying the child or young person and what right/s they have to make healthcare decisions for the child. This might include sighting a court order, certificate of approval as a foster carer or kinship carer (S82, S131)⁹³ or other legal document/s which identify:

- the patient as the child or young person who has been placed in care
- the adult accompanying them as the person who has responsibility for the patient
- the extent of that responsibility in terms of whether they can make decisions about daily care or the long-term care, wellbeing and development of the child.

Even where the person accompanying the child produces some evidence of their responsibilities for the child as nominated above, it is advisable for health practitioners to liaise with the Department of Communities (Child Safety), Child Safety Service Centre Managers or Regional Directors, regarding the current legal status of the child and the nature of out-of-home care arrangements, as these arrangements, particularly kinship and foster carer approvals, do change quite regularly.

93. Issued under the *Child Protection Act 1999* (Qld) s82(1)

3.1.5 How to assess whether a child or young person is ‘Gillick competent’ and has capacity to give consent to healthcare

To establish that a child or young person has capacity to consent to healthcare, the health practitioner can carry out an assessment to show the patient has sufficient understanding, intelligence and maturity to appreciate the nature, consequences and risks of the proposed healthcare, and the alternatives, including the consequences of not receiving the healthcare.

When assessing a child or young person’s capacity, the following issues should be considered ⁹⁴:

- the age, attitude and maturity of the child or young person, including their physical and emotional development
- the child or young person’s level of intelligence and education
- the child or young person’s social circumstances and social history
- the nature of the child or young person’s condition
- the complexity of the proposed healthcare, including the need for follow up or supervision after the healthcare
- the seriousness of the risks associated with the healthcare
- the consequences if the child or young person does not have the healthcare
- where the consequences of receiving the healthcare include death or permanent disability, that the child or young person understands the permanence of death or disability and the profound nature of the decision he or she is making.

The more complex the healthcare or more serious the consequences, the stronger the evidence of the child or young person’s capacity to consent to the specific healthcare will need to be. In these situations, it is recommended that the assessment is carried out by a medical practitioner.

The health practitioner documents fully in the patient’s clinical record the assessment they have carried out, including the details which influenced their decision as to whether the child has capacity.

Maturity and intellectual development varies from one individual to another and an assessment of a child or young person’s capacity is performed for each new healthcare decision. However, as a practical rule of thumb:

- a young person aged between 16 and 18 is most likely able to consent
- a young person aged between 14 and 16 is reasonably likely to be able consent
- a child under the age of 14 may not have the capacity to consent, except for healthcare that does not carry significant risk ⁹⁵.

A child who has the capacity to consent for a low risk, simple procedure like receiving an x-ray or suturing of a small wound, may well not have capacity to give consent to a major heart operation with greater risks and more serious consequences.

A child who is intellectually disabled may still be capable of consenting to and possibly refusing specific healthcare depending on the specific circumstances.

Where a child or young person does not have capacity to give consent, this does not reduce the significance of their involvement in decision-making, and health practitioners would communicate with them and involve them as much as possible in decisions about their care.

94. *Consent to Treatment of Children* Circular from the Chief Health Officer Issue No 23 December 2006.

95. *Consent for Treatment and Confidentiality in Young People*, September 2004, the former Medical Practitioners Board of Victoria p1-6

3.1.6 Can a child or young person with capacity to consent decline healthcare?

A child or young person who has capacity to consent to healthcare can also decline healthcare.

In this situation a medical practitioner may:

- explore carefully the reasons for the declining to give consent
- encourage the child or young person to involve a parent or other adult before reaching a decision
- explore the reasons why they do not wish to involve a parent or other adult (the health practitioner may need to consider overruling a child or young person in some circumstances, for example, if there are child protection concerns)
- consider whether alternative healthcare might be acceptable
- consider involving other members of the multidisciplinary team, an independent advocate or a named or designated doctor for child protection, if their involvement would help with the decision-making process
- consider obtaining a second opinion about the child's capacity if there is any doubt
- document the details of the above discussions in the clinical record
- remember that to be valid, consent is voluntary and free from any pressure by health practitioners, parents or others.

Remember, that where there is significant risk from a child or young person declining to consent to healthcare, it is advisable to seek advice from a senior medical practitioner. Ultimately, however, a court may override a child or young person's decision and the first and paramount consideration will always be the welfare, wellbeing and interest of the child or young person. Legal advice may also be required. If unsure, refer to the Executive Director of Medical Services or their representative.

3.1.7 How to deal with disputes about capacity to consent or the proposed healthcare

Both parents and older children or young persons may hold concurrent ability to consent to the child or young person's healthcare. In most cases, this will not cause a problem, but disagreement sometimes arises between the child or young person, parent or guardian about what healthcare is best for the child or young person.

If the child or young person has sufficient capacity to consent to the specific healthcare, and the health practitioner considers it is in their best interests, their wishes are usually honoured. However, particularly for healthcare where there are significant risks, it will usually be appropriate to consider seeking a second opinion from a senior, experienced, medical practitioner and obtaining legal advice.

In Queensland, it is still unclear whether someone with parental responsibility can overrule the declining of consent expressed by a child or young person who has capacity to consent on a specific matter. Until this is resolved, Queensland Health recommends legal advice be obtained regarding a possible application to the court for a ruling if taking the above steps does not resolve the issue.⁹⁶

Where a medical practitioner, health practitioner, parent or guardian disagree about the child or young person's capacity to make a decision, it is in the best interest of all parties concerned to consider seeking legal advice, particularly where there are significant risks to the patient in receiving or not receiving the healthcare.

In some situations it may be appropriate to consider delaying the healthcare until such time as the child or young person has matured sufficiently to have capacity to make the decision for themselves.

96. Peter J.M. MacFarlane and Simon J Reid, *2006 Queensland Health Law Handbook 16th Edition*, Queensland Department of Health pp81-83

3.1.8 Do parents or guardians need to be present at the time of healthcare being provided?

In situations where parents or guardians have given advance consent to a specific form of healthcare being carried out, for example, oral health clinic and other outreach programs, it is good clinical practice to encourage parents to attend with the child. The reasons for this include:

- ensuring compliance with the Queensland Health Ensuring Correct Patient, Correct Site and Side, Correct Procedure (3Cs) Policy (<http://qheps.health.qld.gov.au/psq/3cs/docs/3cs-policy.pdf>) (3Cs) Implementation Standard (<http://qheps.health.qld.gov.au/psq/3cs/docs/3cs-standard.pdf>)
- confirming the child's identity
- confirming the site and side of the procedure
- giving consent to additional healthcare or a changed healthcare plan
- reassuring and supporting the child
- providing supervision after the healthcare.

In circumstances where the parent or guardian does not attend with the child or young person, and the health practitioner has concerns that consent given in advance may not be valid, the healthcare would be postponed until the validity of the informed consent has been confirmed.

For more discussion refer to [section 4.7 Childhood and school-based programs \(including oral health and immunisations\)](#).

3.2 Informed decision-making for urgent and life-saving healthcare to children and young persons

3.2.1 General approach to consent for urgent and life-saving healthcare to children and young persons

In urgent and life-saving situations, health practitioners are expected to make reasonable attempts (considering the circumstances and time permitting) to obtain consent from the child or young person (if they have capacity to do so) and/or from someone with parental decision-making responsibility. However, if this is not possible, healthcare is provided without unreasonable delay if the health practitioner believes on reasonable grounds it is immediately necessary to save a child or young person's life or to prevent serious injury to their health.

In such cases the healthcare is:

- in the best interests of the child or young person
- the minimum necessary for the purpose of saving the child or young person's life or to prevent serious injury to their health
- where there is more than one option, the one that is consistent with good medical practice and leaves most future choice open to the child or young person.

The health practitioner making the decision to provide healthcare in the absence of consent is responsible for documenting clearly in the patient's clinical records:

- that consent was not obtained
- the reasons for providing healthcare without consent including:
 - the assessment of the child or young person's capacity to consent
 - any steps taken to contact someone with the authority to consent for the child or young person and any resulting discussions
 - the healthcare is immediately necessary to save a child or young person's life or to prevent serious injury to their health.

Where the child or young person is unable to consent and there is no one else available with authority to consent on their behalf, the *Criminal Code Act 1899*⁹⁷ removes criminal liability for a surgical operation or medical treatment performed or provided in good faith, with reasonable care, and for the child's benefit.

3.2.2 Blood and blood product transfusions in children and young persons

Usually consent is required before providing a blood or blood products transfusion to children and young persons. It is important the decision-maker understands what range of treatment options and alternatives to blood and blood products transfusion are available, as some may be more acceptable than others (refer to [section 4.3 Blood and blood products transfusion](#)).

However, if a child requires a blood transfusion as a life-saving measure for a condition the child currently has, the *Transplant and Anatomy Act 1979*⁹⁸ allows for a transfusion to be given without the parents' consent (whether due to declining of consent or lack of time). Such a situation may arise in relation to the child of Jehovah's Witness parents. A medical practitioner can administer a blood transfusion as a treatment in the absence of consent if certain conditions are met:

- the medical practitioner is of the opinion that the administration of a blood transfusion is necessary to preserve the life of the child or young person
- before the administration of the blood transfusion, either:
 - a second medical practitioner is required to examine the child in person and be of the opinion that the administration of a blood transfusion is necessary to preserve the life of the child or young person or
 - the medical superintendent of a base hospital (or equivalent) is satisfied that a second medical practitioner is not available to examine the child and that a blood transfusion is necessary to preserve the life of the child, and they consent to the transfusion.

The medical practitioner/s documents clearly in the patient's clinical records:

- that consent was not obtained
- the current condition requiring the transfusion
- the reasons for providing treatment without consent including:
 - the transfusion is necessary to preserve the life of a child or young person
 - the assessment of the child or young person's capacity to consent
 - any steps taken to contact someone with the power to consent for the child or young person
 - the details of the second opinion
 - the details of any discussions with and consent from the medical superintendent.

Where a child or young person has sufficient maturity to have capacity in relation to receiving a blood transfusion, they may consent for themselves. However, the *Transplant and Anatomy Act 1979* (Qld) is silent with regards to those situations where a child may be Gillick competent and may have capacity to make decisions about his/her healthcare, and is refusing a blood transfusion.

If there is no doubt the young person has the capacity to decide and they decline to consent, it is likely their decision needs to be honoured. However, this situation has not been adequately tested in the Australian courts and it is recommended legal advice be considered.

Additional difficulties may arise where a health practitioner believes a child or young person is being pressured into refusing or accepting treatment with blood or blood products to the extent their capacity may be in doubt.

97. *Criminal Code Act 1899* (Qld) s282

98. *Transplantation and Anatomy Act 1979* (Qld) s20

Where there is doubt about a child or young person's capacity to decide, or they have capacity and are refusing the administration of blood or blood products, medical practitioners can seek guidance (including a second opinion if necessary) from a senior medical practitioner and/or obtain legal advice as required. In some cases it may be necessary to seek the court to intervene to authorise treatment.

Where those with parental responsibility object to the administration of a blood transfusion for religious or other reasons, they are also able to seek the intervention of the court, which would decide the matter in the child's best interests.

3.3 Examination of a child or young person without the consent of parents under the *Child Protection Act 1999*

A health practitioner may medically examine or treat a child or young person in relation to specific child protection concerns under the *Child Protection Act 1999*, where a police officer or authorised child safety officer requests this, or there is an appropriate order⁹⁹.

The child or young person consents to the examination where they have capacity to do so, but parental consent is not required and does not need to be sought.

3.4 When is consent from a parent, guardian or child/young person not enough?

Consent is obtained from the appropriate court where treatments are considered to be extremely high risk, ethically sensitive or have profound life-changing effects. Neither consent from the parent nor a child/young person with capacity to make the decision is sufficient in such cases¹⁰⁰.

Examples of treatments where only court authorisation of the healthcare is valid include:

- gender reassignment of a child
- sterilisation of a child.

This is not an exhaustive list and further information is available at these websites:

- Queensland Law Reform Commission
[http://www.qlrc.qld.gov.au/reports/r51v1.pdf](http://www qlrc.qld.gov.au/reports/r51v1.pdf)
<http://www.qlrc.qld.gov.au/reports/r51v2.pdf>
- Commission for Children & Young People & Child Guardian www.ccydpcg.qld.gov.au.

It is recommended that legal advice be obtained in such cases or if doubt exists as to who has the authority to make decisions about any healthcare of a child or young person.

99. *Child Protection Act 1999* (Qld) s97

100. *Consent to Health Care of Young People - Volume One - The Law and Need for reform* (1996) p158-164, Queensland Law Reform Commission

Part 4 Informed decision-making in specific healthcare situations

4.1 Do patients need to give informed consent to intimate examinations?

Informed consent is required before an intimate examination is carried out on a patient.

Intimate examinations include examination of the breasts, genitals and anus/rectum. However, an intimate examination can only be defined by what an individual patient perceives as being intimate. For example, when conducting a clinically necessary cardio-respiratory examination it may be necessary to expose, move or otherwise touch the breasts. Some patients find this type of examination intimate or distressing even though the primary purpose is not a breast examination.

Even when the health practitioner is the same gender as the patient, care is taken to ensure a patient's decision surrounding an intimate examination is fully informed.

In addition to obtaining informed consent prior to any examination, the patient might find intimate, the dignity of the patient needs to be respected, including:

- offering privacy to undress
- only helping to undress a patient after they have clearly given consent to such assistance
- using curtains
- using drapes (sheet/blanket) to cover the patient
- only exposing the minimum necessary for the examination being conducted at that time (that is, if a full examination is required, covering the areas that are not being assessed at that moment).

Best practice indicates that health practitioners offer a chaperone of the patient's choice for any examination the patient might find intimate.

Patients have a right to decline such examination as long as the decision is informed. Similarly, they may ask for a particular chaperone to be present or a particular health practitioner (maybe gender-based) to undertake the examination. Such requests are complied with where possible. However, where this is not the case, or if it would mean deferring the examination to a different time, the patient is provided with appropriate information about how this might change the risks/benefits/healthcare options so they can make an informed decision.

If a patient refuses another health practitioner is to be present during the examination, this should be documented including the actions taken. A staff member should remain within hearing outside the door/screen of the examination area (as protection for the examining health practitioner).

It is usually sufficient to rely on verbal consent and to document the discussions and the consent, and include the name of the chaperone or support person in the patient's clinical record. However, other situations may require written consent, such as prior to an intimate examination on a child or young person, or an intimate examination that will be conducted on an anaesthetised patient.

4.2 What are the consenting issues for mental health patients?

4.2.1 What are the limits of the mental health legislation?

The *Mental Health Act 2000* does not provide authorisation for non-consensual treatment (treatment without consent) except in relation to a person's mental illness. Patients who are subject to an involuntary treatment order under the *Mental Health Act 2000* may still have capacity to give consent to or decline healthcare in respect of specific healthcare matters not related to their mental illness (for example, the use of antibiotics for a chest infection, or a surgical procedure on a gangrenous limb).

An assessment of the patient's capacity to make decisions about healthcare for a specific matter is undertaken in the usual way and documented appropriately. Where such patients lack capacity to consent to healthcare for a condition unrelated to their mental illness, the consent of a substitute decision-maker is required, enabling them to be treated for that condition outside of the *Mental Health Act 2000* as in [section 2.1 What is different for adults who lack capacity to make informed decisions](#) and [section 3 Informed decision-making and consent for children and young persons](#) of this guide.

4.2.2 Can electroconvulsive therapy (ECT) be given without consent?

A number of particular types of treatment are regulated under the *Mental Health Act 2000*, including electroconvulsive therapy (ECT).

For both voluntary and involuntary patients, the patient is required to give informed consent to receiving ECT as set out in the *Mental Health Act 2000* before receiving these forms of treatment except in limited circumstances¹⁰¹:

- A person who has not given informed consent can only be given ECT with the approval of the Mental Health Review Tribunal, following an application to the Tribunal by a psychiatrist.
- In an emergency, ECT can be given for up to five days without the Mental Health Review Tribunal's approval under the following conditions:
 - a psychiatrist and the medical superintendent of the patient's treating health service are required to certify in writing the treatment is necessary to save the patient's life or prevent the patient from suffering irreparable harm; and
 - the psychiatrist is required to simultaneously make a treatment application to the Mental Health Review Tribunal.

4.3 Blood and blood products transfusion

4.3.1 What consent is needed and what documentation is to be used?

Currently, Queensland Health procedure specific consent forms include a statement covering the patient's consent for blood transfusions for that specific procedure, if required. A separate specific transfusion consent form is not required unless the patient has a significant change in health status or where the nature of the intended healthcare changes.

101. *Mental Health Act 2000* (Qld) s138-140

A Queensland Health [Blood and Blood Products Transfusion Consent form](#) is required for each blood and blood products treatment that involves the administration of:

- fresh blood
- fresh blood products, for example:
 - platelets
 - fresh frozen plasma (FFP)
 - cryoprecipitate.

Written consent is not required for fractionated blood products carrying lower risks than fresh products, for example:

- immunoglobulin
- coagulation products
- albumin.

Some conditions, such as those requiring chemotherapy, or patients with blood dyscrasias, may require multiple transfusions of blood and blood products. To meet the above need a section within the procedure specific form, [Blood and Blood Products Transfusion Consent](#) was developed. This consent document is unique in that it includes the possibility of consenting to multiple blood and blood product treatments for a medical condition for a definable period of time. Start, frequency and approximate end dates of the transfusions must be documented on the consent form. Where a course of transfusion treatment needs to change due to a patient's change in condition, or a change in the treatment program (refer to [section 1.11 What is the lifespan of a written consent?](#)), a fresh consent to the new course of treatment needs to be obtained and documented with the obligation to warn again of risks that may arise.

Separate blood and blood products patient information sheets are available on the informed consent website and are given to patients who knowingly will require blood for a procedure. The information sheets include links to the National Health and Medical Research Council (NHMRC)¹⁰² and the Australian Red Cross Blood Service¹⁰³ websites.

For children and young persons refer to [section 3.2.2 Blood and blood products transfusions in children and young persons.](#)

4.3.2 Declining of consent to a blood and blood products transfusion

Adult patients with capacity to decide on the issue can decline a blood or other blood products transfusion. A health practitioner is obliged to respect such a decision and continue to provide other alternative forms of healthcare acceptable to the patient.

In addition, to ensure their decision is appropriately informed, the patient will need to understand the details about the range of healthcare options available, the risks, and the effectiveness in their clinical situation. This might include:

- the extent they are derived from or contain blood cellular components, are purified or fractionated from plasma, or are made artificially and not derived directly from blood
- the availability and appropriateness of other technologies such as autologous transfusion, or cell savers.

As with other decisions about healthcare, depending on the clinical urgency, patients are given sufficient time to reflect on the information, consult with those close to them or other advisers, and have their questions answered before making decision.

102. National Health and Medical Research Council [Online: accessed 16 November 2011] [www.nhmrc.gov.au/guidelines/publications/subject/Blood and blood products](http://www.nhmrc.gov.au/guidelines/publications/subject/Blood%20and%20blood%20products)

103. Australian Red Cross Blood Service [Online: accessed 16 November 2011] www.transfusion.com.au/Consent-and-Risk.aspx

Where a medical practitioner reasonably considers an adult patient has an impaired capacity to make a decision about their healthcare, and a transfusion of blood/blood products is required urgently to meet an imminent risk to the life or health of the patient, a transfusion may be administered without consent as long as the medical practitioner does not know of an objection by the patient in an Advance Health Directive ¹⁰⁴.

Patients of the Jehovah's Witness faith may carry a card containing information about their views about such healthcare, or have made an Enduring Power of Attorney in which they outline their wishes about receiving blood/blood products in the event they lack capacity to make decisions about their healthcare. Where these are valid, they are followed, and the decisions of an attorney respected. For more details refer to [section 2.2 Who can consent for adult patients who lack capacity to make a decision to consent to healthcare or not? \(Substitute decision-makers\)](#).

Where additional complexities arise, for example, when a family disputes whether or not blood is to be provided to the patient or where the terms of the Advance Health Directive or Enduring Power of Attorney are unclear, legal advice may be required.

For children and young persons refer to [section 3.2.2 Blood and blood products transfusions in children and young persons](#).

4.4 Maternity care

During pregnancy, women are provided with information by a variety of health practitioners, including midwives, medical and health practitioners. The information includes maternity models of care available, birth options, risks and benefits of pain relief, infant feeding methods and care of the neonate. Provision of this information in the antenatal period provides the patient with time to consider options and opportunities to clarify information. This assists the woman to make informed decisions during her pregnancy, birth and postpartum care.

If a woman in the care of a midwife chooses not to accept a care pathway as recommended by the Maternity Team, midwives are advised to refer to the Australian College of Midwives National Guidelines for Consultation and Referral: Care outside the Guidelines ¹⁰⁵.

The statewide Pregnancy Health Record may be used to document a woman's birth preferences and clinical history and so provide a framework for clinicians in providing timely and appropriate information. However, later changes of birth preferences or refusal of care should be discussed and respected in accordance with usual practice.

While patients are presumed to have capacity, during the birth process, pain, medications and fatigue may impact on a woman's capacity to give informed consent, and at times she may temporarily lack capacity to make decisions (refer to [section 2.1 What is different for adults who lack capacity to make informed decisions?](#) and [section 2.3 What situations are there where consent may not be needed to provide healthcare to an adult who lacks capacity?](#)).

During maternity care, information in [section 4.1, Do patients need to give informed consent to intimate examinations](#), applies.

When providing information about water birth, it is essential to clarify with the woman:

- the difference between water immersion in labour and a water birth:
 - water immersion in labour are techniques used for relaxation and pain relief
 - water birth is giving birth to an infant while immersed in water
- an unplanned water birth is a potential outcome of using water immersion in labour ¹⁰⁶.

Unexpected outcomes during labour may change a woman's expectation for her birth. Women are supported in their choices during their birth, regardless of previously expressed preferences.

104. *Guardianship and Administration Act 2000* (Qld) s63

105. *National Midwifery Guidelines for Consultation and Referral: Care outside of Guidelines*, 2nd edition, 2008, Australian College of Midwives.

106. *Warm Water Immersion during Labour and Birth*, C-obs 24, July 2008, The Royal Australian and New Zealand College of Obstetricians and Gynaecologists College Statement [On-line: accessed 16 November 2011]
www.ranzcog.edu.au/component/content/article/503-c-obs/424-warm-water-immersion-in-labour-and-birth-c-obs-24.html

A documented consent form is not required for a normal vaginal birth. However, documented consent using a Queensland Health procedure specific consent form is required for:

- caesarean section
- blood and blood products transfusion
- complementary feeds of infant formula for breastfeeding infants.

In future, other circumstances requiring statewide written consent may be identified and the appropriate consent forms and documentation in the patient's clinical record is required.

All birth plans and consents are to be filed in the patient's clinical record and retained in accordance with the Queensland Health Retention and Disposal of Clinical Records Policy (http://qheps.health.qld.gov.au/clinical_info_mgt/docs/9442_ret_st_dis.pdf).

4.4.1 Termination of pregnancy

Current Queensland legislation ¹⁰⁷ makes both surgical and medical termination of pregnancy (abortion) a criminal offence except in situations where the termination of pregnancy may be excused under section 282 of the *Criminal Code Act 1899* (Qld).

For a person to be entitled to the excuse offered by section 282, the court would need to accept they performed or provided a surgical operation on or medical treatment of a woman or an unborn child:

- to preserve the mother's life, and
- that the person acted in good faith and with reasonable care and skill, and
- that performing the operation or providing the medical treatment was reasonable having regard to the patient's state at the time and all the circumstances of the case.

The courts have interpreted the term "preservation of the mother's life" as encompassing situations where a procedure:

- (a) is necessary to preserve the woman from a serious danger to her life or her physical or mental health (not being merely the normal dangers of pregnancy and childbirth), which the continuance of the pregnancy would entail, and
- (b) in the circumstances, not out of all proportion to the danger to be averted ¹⁰⁸.

A pregnant patient's physical and psychological state is therefore a most relevant consideration. Each patient's circumstances are unique and would need to be assessed independently. Health practitioners face criminal prosecution if the law is not adhered to.

Circular number 3/2008 from the Chief Health Officer entitled Termination of Pregnancy ¹⁰⁹ states:

At public and private facilities, it is standard professional practice to provide counselling to women undergoing termination of pregnancy. This includes information on the legal, financial, psychological, psychosocial and medical implications of the termination of pregnancy as well as discussion and written information about issues related to termination. Counselling is also available during and after the termination.

It is paramount that the general principles of obtaining valid informed consent prior to termination of pregnancy are adhered to, including ensuring:

- the patient has capacity

107. *The Criminal Code Act 1899* (Qld) s224-226 Schedule 1

108. Peter J.M. MacFarlane and Simon J Reid, 2006 *Queensland Health Law Handbook 16th Edition*, Queensland Department of Health

109. http://qheps.health.qld.gov.au/cho/Circulars/3_2008_abortion.pdf [Intranet Queensland Health staff only]

- the patient has received appropriate support and counselling and understands all the options available to her, including the different methods of termination and the option of continuing the pregnancy
- the consequences, including the material risks, of each option
- the decision is voluntary and free from coercion.

In all cases where a termination of pregnancy is considered, the assessment of the patient by the medical practitioner, consenting discussions and the information provided, is to be fully documented in the patient's clinical record. A procedure specific consent form is used and annotated appropriately.

It is vital each of the medical practitioners recommending or performing the termination document their assessment and clinical opinion fully in the patient's clinical records. This would include sufficient details to provide evidence to meet the legal tests above that:

- the patient has capacity
- a serious danger to the women's life or her physical or mental health exist
- the risks involved in proceeding with the pregnancy and termination of the pregnancy
- the clinical reasoning as to why, on balance, the termination is necessary to avert the serious risks identified and
- the risks of the termination are proportionate to the risks avoided if the pregnancy were to continue.

Where adults lack capacity, the *Guardianship and Administration Act 2000* (Qld)¹¹⁰ requires the Queensland Civil and Administrative Tribunal (and not a substitute decision-maker or legal guardian) to provide consent to a termination of pregnancy as a matter of special healthcare.

Where a termination of pregnancy is being considered for a child or young person, issues can arise as to whether the child or young person has sufficient capacity to make a decision, whether the parents or legal guardian/s may consent or whether, in the particular circumstances, a court order would be warranted to sanction the procedure as being in the best interests of the child or young person. Health practitioners are encouraged to seek legal assistance in such cases.

In some cases, and within a reasonable timeframe, the health practitioner may consider referring the case to a Clinical Ethics Review Committee for advice.

Conflict between the health practitioner and the patient may arise when the practitioner is unable to provide a termination of pregnancy due to clinical appropriateness, available facilities or legal reasons. This conflict arises because the public expectation of a termination is often different to what can be provided by the local or referring medical practitioner. Clear documentation of the case includes:

- both the referring medical practitioner and the treating medical practitioner reasons and any additional factors for the request
- the reasons for not providing the termination and what was done to meet duty of care
- the provision of alternative options, which may include referral to another suitably qualified medical practitioner or a private clinic within a reasonable timeframe for the circumstances.

If the medical practitioner declines to perform the termination of pregnancy (due to religious or ethical reasons), the obligation of care to ensure handover or referral to another suitably qualified medical practitioner is to occur within a reasonable time frame for the circumstances.

Any future Queensland Health policy or guidance on termination of pregnancy should be followed.

110. *Guardianship and Administration Act 2000* (Qld) s71

4.5 Open access services

The open access system allows a medical practitioner, usually a general practitioner (GP), within the community, the opportunity to directly schedule elective procedures for their patients without them having first been examined by a specialist proceduralist. Consequently, the proceduralist will generally not have the opportunity to discuss the healthcare options, risks, complications and outcomes with the patient until the day of procedure.

Open access units are usually supported by nursing and other healthcare staff who provide extensive information (such as explanatory leaflets) to patients regarding their prospective healthcare. Staff working in open access pre-admission clinics have a responsibility to provide healthcare information – including that related to anaesthesia – to patients prior to this procedure being conducted, preferably at the time of booking to having the procedure performed. This gives the patient sufficient time to consider the information to make an informed decision.

The referring practitioner has a duty to fulfil this initial obligation, outlining possible risks and complications of both the procedure and any anaesthesia required. However, while the consenting process is a multi-disciplinary team approach, the responsibility for ensuring the patient has received sufficient information to make a valid informed decision rests with the practitioner performing the procedure. This includes confirming the patient's level of understanding of the information previously given and giving them the opportunity to receive additional information and to have any questions answered in a way they can understand.

4.6 Healthcare administered in a clinical trial, medical research or experimental healthcare

All clinical trials in Queensland require research and/or ethics approval. The Queensland Health Research Management Policy clearly outlines the consent requirements to be obtained from participants. Visit <http://www.health.qld.gov.au/qhpolicy/docs/pol/qh-pol-013.pdf>

4.7 Childhood and school-based programs (including oral health and immunisation programs)

There is a tension between providing healthcare to large numbers of patients and the need to ensure valid informed consent has been provided.

Valid informed consent is required before examining or treating children and young persons in such programs. In particular, the principles and processes described in the following sections will apply:

- [section 1.6 What process of obtaining informed decision-making needs to be followed?](#)
- [section 3 Informed decision-making and consent for children and young persons.](#)

Where general consent is obtained to participate in a program involving multiple healthcare episodes over a period of time, confirmation of ongoing consent is required on each occasion a patient attends for healthcare. (Refer also to [section 1.11 What is the lifespan of a written consent?](#))

It is usually sufficient to obtain verbal consent on the second and subsequent occasions where a signed consent to a program of healthcare already exists, but any discussions and confirmation of the consent are to be documented in the patient's clinical records on each occasion. If there is any significant change in the patient's condition or healthcare options, a fresh consent process is required.

If consent to all or part of the program is declined (for example, not wanting to receive one component of a multiple vaccination) or withdrawn, this decision and the reasons (if known) is documented in the patient's clinical record. (Refer to [section 1.9 Can a patient or decision-maker decline or withdraw consent to healthcare?](#) for more details.)

In addition to facilitating the consent process, there are additional reasons for someone with parental responsibility to be present whenever children and young persons attend for healthcare, as described in [section 3.1.8 Do parents or guardians need to be present at the time of healthcare being provided?](#)

4.7.1 Infants, pre-school children and young persons who lack capacity to give consent

It is extremely unlikely pre-school children have sufficient capacity to consent and so valid informed consent from somebody legally able to provide it is required. Similarly, where older children and young persons lack capacity to consent to a specific form of healthcare for themselves, a health practitioner will need to obtain consent from an appropriate person who is legally able to provide it.

In most cases, the appropriate person will be a parent or legal guardian. [Section 3.1.2 Who can consent for a child or young person?](#) gives more details about whether other people are able to consent or not.

If a child is brought for healthcare by a step-parent, grandparent, older sibling or other carer who is not a parent or legal guardian, they are not legally able to provide valid consent or sign for the same. The healthcare cannot be given without the valid consent from an appropriate person except in the circumstances referred to in [section 3.2 Informed decision-making for urgent and life-saving healthcare to children and young persons.](#)

Approved foster carers and approved kinship carers are able to consent for examinations and minor low risk healthcare that would be considered a matter of daily care (for example, dental examination and minor, low risk dental treatments), and on subsequent visits to ongoing treatment (for example, where a signed consent to a healthcare program has already been obtained from a parent or guardian). However, these carers are not able to give consent to a new or changed course of healthcare with significant or long-term consequences or greater risks that would not be considered a matter of daily care. Refer also to [section 3.1.3 What about children who are placed in care?](#)

Where the specific healthcare provided will depend on the results of an initial examination, the initial consent is limited to the examination and additional consent to provide specific healthcare is obtained once the findings are known and appropriate information has been provided.

In circumstances where the parent or guardian does not attend with the child or young person, and the health practitioner has concerns that consent given in advance may not be valid, the healthcare is to be postponed until the validity of the informed consent has been confirmed.

4.7.2 Older children and young persons who have capacity to consent to healthcare

Older children and young persons who have capacity to give consent can do so themselves. However, even if the patient has capacity, it may still be prudent to encourage them to involve an adult as described in [section 3.1.1 At what age can children and young persons consent for themselves?](#)

4.8 Public health orders

Chapter 3 of the *Public Health Act 2005* allows for the mandatory detention by order of the chief executive ¹¹¹, or detention, medical examination and treatment by order of a magistrate ¹¹² of persons with a controlled notifiable condition ¹¹³, for example, tuberculosis, HIV or avian influenza.

The medical practitioner is required to give the subject of the order an explanation of the examination or treatment to be undertaken in a way likely to be readily understood by them, and allow them an opportunity to submit to the examination or treatment voluntarily ¹¹⁴.

111. *Public Health Act 2005* (Qld) s112-115

112. *Public Health Act 2005* (Qld) s116-142

113. *Public Health Regulation 2005* (Qld) Schedule 1

114. *Public Health Act 2005* (Qld) s133

4.9 What are the informed decision-making issues for off-label use of medications?

Medications are frequently used outside their marketing approval, that is, not in line with the indications, dose or route of administration which has been approved by the Therapeutic Goods Administration (TGA).

Where medications are used off-label, health practitioners:

- ensure appropriate consent is always obtained
- refer to the current Queensland Health List of Approved Medicines (LAM) (www.health.qld.gov.au/qhcss/mapsu/sdl.asp) [Online: accessed 16 November] where some off-label use of items is reflected in specific restrictions
- when the item is not on the LAM, local procedures (for example, protocols applicable to certain groups of patients or approval by the local or District Medicines or Drug and Therapeutics Committee or medical superintendent) are followed to obtain approval to prescribe to an individual patient.

When it is accepted practice for the use of an off-label medication, the normal process of consent to treatment is followed and it would not always be necessary for written consent to be provided, as long as the consent discussions are appropriately documented in the patient's clinical records. A discussion with the patient or decision-maker would include:

- an explanation that the medicine is usually used for a different purpose
- the potential benefits of treatment with the medicine
- possible alternative treatments (including the option of no treatment)
- potential risks, including drug interactions and side effects
- additional information about any uncertainties associated with its use
- any additional information sought by the patient or decision-maker.

However, as with other treatments where there are known significant risks, the treating health practitioner ensures written consent is provided ¹¹⁵.

In the absence of high-quality evidence supporting routine off-label use of a medicine, in exceptional circumstances, its use may still be justified in a particular patient where the potential benefits are deemed to outweigh the potential risks. The patient or decision-maker demonstrates they clearly understand the relevant information and provide fully informed written consent. In these circumstances, approval is obtained for individual 'exceptional use' by the local research ethics or drugs and therapeutics committee ¹¹⁶.

4.10 What are the informed decision-making issues when using medicines via the Special Access Scheme (SAS)

The Therapeutic Goods Administration (TGA) website (www.tga.gov.au/hp/access-sas.htm) [Online: accessed 16 November 2011] provides the following information:

The SAS allows an approval to be given for individual patients to access unapproved therapeutic goods (that is, medicines that do not have marketing approval in Australia) under a range of circumstances and according to the health status of the individual. For example, a person who is terminally ill may need access to the SAS for reasons

115. *Off-Label Use of Registered Medicines and Use of Medicines under the Personal Importation Scheme in NSW Public Hospitals- A Discussion Paper* Prepared by a Working Group of NSW TAG Inc September 2003 [Online: accessed 16 November 2011]

www.ciap.health.nsw.gov.au/nswtag/publications/otherdocs/off_label_use_registered_medicines.pdf

116. Gazarian M, Kelly M, McPhee J et al. *Off-label use of medicines: consensus recommendations for evaluating appropriateness*. Medical Journal of Australia 2006;185(10):544-8

quite different to those whose lives are not threatened. Thus, two classifications (Category A and Category B) are defined in the legislation and guidelines. It is the responsibility of the prescriber to classify each patient as either Category A or Category B.

The principles of obtaining informed consent before providing the medication applies as described in [section 1.6.2 Providing sufficient information so the patient or decision-maker can make an informed decision](#). This includes the potential cost to the patient.

It will always be a condition of the approval to supply an unapproved therapeutic good that the patient or the patient's legal guardian be in a position to make an informed decision regarding treatment. Informed consent should be in writing unless there are good reasons to the contrary, and where required under the SAS, the appropriate consent form shall be used.

Visit www.tga.gov.au/about/contact.htm

4.11 What are the informed decision-making issues with obtaining organs for transplantation?

The informed decision-making associated with the obtaining of organs for transplantation is covered in the *Transplantation and Anatomy Act 1979* and these should be followed.

4.12 Where can I get more advice about consent in relation to a particular patient?

Sometimes a situation surrounding the decision-making and consent for a particular patient's healthcare is difficult and complex, with no clear direction, and does not appear to fall within the guidance outlined in this guide. If this occurs, expert advice and assistance is available from:

- Aboriginal and Torres Strait Islander Health Branch (A&TSIHB)
- Commission for Children and Young People and Child Guardian
- Department of Child Safety enquiries
- Queensland Civil and Administrative Tribunal (QCAT)
- Interpreter Service
- Mental Health Act Liaison Officer
- Office of the Adult Guardian.

Professional defence organisations/insurers might be able to give an individual health practitioner advice on general principles or the practitioner's own position, but would be unable to become involved in the management of a Queensland Health Services patient.

Refer to the following section of this guide to obtain [Useful contact details](#) for the above sources of advice.

Part 5 Communication and cultural issues in informed decision-making in clinical healthcare

5.1 What about patients who have additional communication needs?

When a patient has limited health literacy, low or no English proficiency, is visually or hearing impaired, or has an intellectual disability, health practitioners use communication methods appropriate to the situation and the patient's level of communication. These might include simple, language free of medical jargon audio, diagrams and illustrations, and video or multimedia material. Psychologists, social workers, liaison officers, speech pathologists, teachers, carers or others who know the patient well may be able to offer advice, or support the communication process most appropriate for an individual patient.

Documents supporting the consenting process are available in several languages on the Queensland Health Informed Consent website. Visit www.health.qld.gov.au/consent/html/for_clinicians.asp [Online: accessed 16 November 2011]

A careful assessment of a patient's capacity to make informed healthcare decisions will need to be made (refer also to [section 1.7 Is this adult patient able to make a decision about healthcare themselves?](#)). Where possible, health practitioners confirm understanding by asking the patient or decision-maker to explain in their own words what they have understood about the nature of the proposed healthcare and the consequences of accepting or declining the proposed healthcare options. However, low English proficiency does not in itself indicate low literacy, education or intelligence.

The patient's limited communication abilities and the methods used to provide information are documented in the patient's clinical record, along with sufficient detail to provide evidence the patient understood the information.

5.2 Use of interpreters

Health practitioners are to comply with the prevailing Queensland Health policy regarding the use of interpreters ¹¹⁷.

Patients who have difficulty communicating in English are offered an accredited or recognised interpreter during the informed consent process. The ability to converse in English does not necessarily indicate that a person comprehends the English spoken by healthcare professionals or that the person understands written English. If there is any doubt as to a person's ability to communicate in and comprehend English, an interpreter should be engaged.

If an on-site interpreter is not available, a video remote (video conference) or telephone interpreter should be engaged.

Multicultural Queensland – making a world of difference, Queensland Government Multicultural Policy outlines that:

- non-professional interpreters should not be used unless the situation is urgent and a professional interpreter is unavailable
- as far as practicable, friends and family members are not used as professional interpreters
- children and young relatives are not appropriate in any context ¹¹⁸.

117. *Multicultural Queensland – making a world of difference, Queensland Government Multicultural Policy 2004* p10 outlines order-of-preference protocols for engaging interpreters and professional interpreters versus family and friends and bilingual staff as interpreters.

118. *Ibid* p10

The health practitioner may be asked to justify any decision not to use an accredited interpreter in the specific circumstances, and the circumstances including the reasons for using a non-accredited interpreter should be clearly documented in the patient's clinical records.

It is not acceptable to simply provide booklets and pamphlets for the patient and/or interpreter to read alone. The interpreter should be asked to 'sight translate' the content of the consent form and additional information, for example, medications or post-operative care, to the patient. The information required to be 'sight translated' is of a suitable length (approximately 200 to 300 words). Both the interpreter and health practitioner/delegate are to be present at the time the information is translated and provided to the patient, so that the health practitioner/ delegate can clarify questions that may arise and valid informed consent obtained while the interpreter is present.

It is the responsibility of the health practitioner/delegate to ascertain that the patient has understood the content of the consent form and other information, not the interpreter's.

When the consent form has been signed by the patient, the interpreter usually countersigns the 'interpreter's statement' section of the consent form to indicate:

- he/she has given a 'sight translation' of the consent form and any verbal and written information given by the health practitioner in the language that the patient understands and
- the language translated.

In the event that a video remote or telephone interpreter service is used, the interpreter's name and contact details are documented on the consent form by the treating health practitioner/delegate in the 'Interpreter's statement' section.

Where a patient declines to give consent, this is documented appropriately in the patient's clinical record and the interpreter asked to countersign the entry, or the interpreter's name and contact details documented if a remote interpreter service has been used.

If the patient declines use of the interpreter services, this is documented in the patient's notes, including the reasons as far as these are known.

Refer to [Useful contact details](#) for ways to contact the Queensland Health Interpreter Service (QHIS) or for multicultural resources not available on the Queensland Health Informed Consent website (www.health.qld.gov.au/consent/) [Online: accessed 16 November 2011].

5.3 What about patients who have cultural and religious needs?

Norms around informed decision-making differ across cultures and some religions. For example, Queensland norms are based around an individual's right to make autonomous decisions. However, this may not always be the case in other cultures, for example a collective decision may be made (prioritising group needs over individual ones) or the decision may be taken or influenced by third party.

From a legal aspect, the principles and requirement for informed consent to healthcare are essentially the same for all Queensland Health patients, whatever their background, and individuals give their own consent to healthcare where they have capacity to do so.

Stereotyping patients is to be avoided as there will always be variations between individuals from the same background. However, health practitioners are expected to be aware that where patients are from a Culturally and Linguistically Diverse (CALD) background (including Aboriginal and Torres Strait Islander patients) this might affect the treating relationship and communication around healthcare decisions to accommodate patients' varied needs. This may mean patients require assistance, or more time for appropriate family members, other advisers including religious or cultural liaison officers, or workers to assist them.

Health practitioners:

- require understanding of these cultural and religious variances
- require understanding of how cultural backgrounds (their own and the patient's) might affect the treating relationship, and take that into account in the informed decision-making process
- have capability to manage and respond to different cultural and religious norms as they play out in relation to informed decision-making
- clarify the needs and expectations of each patient and provide them with the explanations they need about the consenting requirements in Queensland
- are expected to negotiate with patients to accommodate patient's cultural and religious needs where possible
- are skilled at empowering CALD patients by providing information that enables CALD patients to self-advocate or access advocacy support available in the community.

It is beyond the scope of this guide to address all issues related to communicating with patients from a CALD background. Further essential resources can be found in the information for health workers section of the Queensland Health Multicultural Health website. Visit

www.health.qld.gov.au/multicultural/health_workers/for_hlth_workers.asp

5.3.1 How much information does a patient want to receive?

Patients may not want to receive information about their condition or may prefer a third party to be informed on their behalf. Health practitioners clarify the needs, expectations and preferred modes of disclosure and delivery of information with their patients. For example, before ordering an investigation, the practitioner should check with patients how much detail they wish to be told about the result.

Where a patient requests a third party be given the information, the health practitioner obtains the patient's verbal consent before disclosing information to that third party. The patient's consent and other relevant information should be documented in the patient's clinical records.

Where a health practitioner considers a patient's wish not to receive information might impact on the validity of their decision, it is recommended they seek advice from a senior health practitioner and/or obtain legal advice.

5.3.2 Who will make the decision about healthcare?

For cultural or other reasons, patients may wish to consult or defer to a third party. As long as they have the capacity to make such a choice, patients have the right to ask another person to advise them before making a decision.

Health practitioners are prepared to:

- accommodate wishes and make this process possible by collaborating with family and extended community members in the clinical decision-making setting
- allow more time for patients to reflect and consult with family and community members, including, community elders and/or religious leaders, before coming to an informed decision.

In situations where the patient indicates they want a third party to make a consenting decision, the health practitioner would ensure:

- the patient understands they have the right to information and to make the decision themselves
- the patient's decision is informed, and not made simply because the information provided has not been understood or provided in a manner that is not appropriate to that patient's needs
- the patient is free to consult and take advice, but they do need to give their own consent (even if this is to follow the advice of the chosen advisor) and are required to sign any consent form themselves

- the patient understands they are not bound by the advice of that person and can change their mind at any time
- the person advising the patient receives sufficient information to assist the patient make a decision, having obtained permission from the patient to disclose their medical information to third parties
- the patient's decision to seek and follow any advice is made voluntarily and free from any pressure
- the discussions with the patient are meticulously documented on the consent form and in the patient's clinical record.

5.3.3 Imbalance of power

Health practitioners are in positions of power within any healthcare relationship. In many cultures, a health practitioner is highly-trusted and esteemed, and the concept of 'doctor knows best' may act as an impediment to patients making informed decisions.

Patients may smile or nod out of politeness or courtesy or to indicate they are listening or a desire to be a 'good' patient out of respect for a health practitioner's authority and position. They may be reluctant to openly disagree with someone in authority, or ask even basic questions, such as about side effects, for fear of giving insult. CALD patients (including Aboriginal and Torres Strait Islander patients) may also feel ashamed or embarrassed that they do not understand, which may prevent them from communicating that they do not understand.

Where a health practitioner has doubts about the validity of a healthcare decision, they would firstly go over things with the patient again and, if this does not allay their concerns, then escalate their concerns and seek advice from the senior health practitioner (in most cases this will be the treating medical practitioner). They might then consider obtaining legal advice.

5.3.4 Refugees and other vulnerable patients

Individuals who have experienced traumatic human rights abuse (for example, from a refugee background) may be resistant and mistrustful of mainstream services, authority figures, and hospitals. This may be expressed as a declining of consent to healthcare or reluctance to sign a consent form due to a lack of trust or understanding about how it will be used.

On the other hand, people of refugee background may have very different expectations of services, basing it on their experiences of standards of health services in their countries of origin or having unrealistic expectations of what the health system in Queensland can deliver.

Health practitioners should:

- be open and transparent when communicating with these patients
- familiarise themselves with the broader context and background of CALD patients, to identify potential trust issues and barriers to help-seeking behaviours
- explain to patients their rights and obligations within Queensland Health, including their right to ask questions of the health practitioner and the prescribed course of treatment
- identify patient expectations of services and encourage participation in clinical decisions and healthcare
- carefully apply the principles expressed in [section 1.6 What process of informed decision-making needs to be followed?](#)

5.3.5 Culturally-based health beliefs

Patients vary in their acceptance of death, and some will have beliefs which result in a fatalistic attitude towards healthcare. The objective is for the patient to make a valid informed decision that is right for them, even though this may not give the best clinical outcome.

Some patients may wish to consult with spiritual leaders or alternative cultural health providers, healers, and belief systems before, or in addition to, embarking on a Western course of healthcare.

It is recommended health practitioners:

- seek to elicit alternative and culturally-based explanatory models of illness and treatment (An effective tool for this may be the use of hypothetical questions and statements that make it safe for patients to share their beliefs on the cause and cure of the condition. For example, ‘Many of my XX patients believe this condition is caused by xx; what do you believe caused your illness? Many of my patients treat this condition through xxx – is this something that you practise and that I need to take into account in my treatment plan...’)
- adopt culturally appropriate and collaborative ways of working to empower CALD patients including Aboriginal and Torres Strait Islander patients
- communicate openness to supplementary practices
- obtain sufficient information on the use of supplementary practices to be able to assess and inform patients about the potential risks of proposed healthcare, any potential adverse effects or interactions, negotiate the healthcare to be provided and ensure informed decision-making.

5.3.6 Gender issues

There may be strongly held wishes for a patient to be treated by a particular gender of health practitioner. These wishes are respected and accommodated where possible. However, where such a preferred health practitioner is not available and this will impact on the patient’s healthcare, or will have an adverse effect on the risks or consequences for the patient, these are fully explained and suitable alternatives considered. For example, seeking the patient’s views on whether a chaperone is sufficient to allay their concerns. These discussions should be documented in the patient’s clinical record. Refer also to [section 1.9 Can a patient or decision-maker decline or withdraw consent to healthcare?](#)

5.4 What are the consent issues for Aboriginal and Torres Strait Islander patients?

The following has been drafted with the assistance of the Aboriginal and Torres Strait Islander Health Branch. Visit <http://qheps.health.qld.gov.au/atsihb/home.htm> [Online: accessed 16 November 2011]

The overall process of obtaining informed decisions detailed in this guide is the same for Aboriginal and Torres Strait Islander patients as with others. It is important to recognise that as with any group of people, there is a wide range of individual variation and the needs of individuals will have to be assessed on a case-by-case basis. Indigenous Health Workers in the community or Indigenous Hospital Liaison Officers are able to assist health practitioners in the process of obtaining informed decisions from Aboriginal and Torres Strait Islander patients.

This section is best read alongside [section 5.1 What about patients who have additional communication needs?](#)

Issues that are important when obtaining consent from Aboriginal and Torres Strait Islander patients:

- Clear communication is required, in a manner that is understood by the patient or those assisting them.
- Patients may wish to consult with family or others close to them before making a decision.

5.4.1 Clear communication and understanding

Health practitioners need to be aware that for some Aboriginal and Torres Strait Islander patients, English may be their third or fourth language. Health information will need to be provided at the appropriate literacy level. In these situations, visual or spoken information may be more easily understood than written.

The involvement of an Indigenous Hospital Liaison Officer is to be encouraged. However, in some instances they may not speak the patient's first language and an additional intermediary from the patient's language group may be required to help with communication. An accredited interpreter may not be available and the pitfalls of using non-accredited interpreters need to be considered.

In many instances, Indigenous Health Workers play an important role in beginning the consenting discussions and providing information to patients while they are in the community. As informed decision-making is an evolving process, Indigenous Health Workers should document the information and resources provided to patients in the clinical record and ensure this information accompanies patients if they are transferred.

5.4.2 Consultation and consent

Aboriginal and Torres Strait Islander patients may consider a decision to be a shared one involving the needs of the community, relatives and financial implications. As a result, patients may wish to consult with others before making a decision, and may not consent to a particular form of healthcare until a certain person is present or they have discussed it with them. This might mean patients need longer to come to a decision and may give the impression that they are declining consent.

Aboriginal and Torres Strait Islander patients may sometimes appear to wish to delegate a decision to another person for example saying 'My children need to be here before I can have the treatment', or indicating that another person will consent for them. The chosen person may differ depending on the particular issue being considered. Refer also to [section 5.3.2 Who will make the decision about healthcare?](#)

These discussions may have an impact on the time scale required for decision-making, particularly if there is a need for the patient or other party to travel. Careful consideration is given to the selection of any escort or relative that accompanies a patient. Patients are encouraged to identify the most appropriate person for the particular issue they are receiving healthcare for (for example, gender issues), especially where transport is to be arranged.

Even when the patient is accompanied by a relative or escort, the attendance of a third party in a consultation is not necessarily an indication of consent to divulge confidential information to that person. When any patient sees a health practitioner with a third party present, there is an obligation to identify what information the patient wishes given to that third party.

Many patients have difficulty understanding risk. Some Aboriginal and Torres Strait Islander patients may understand risk better by comparison to people they are familiar with. Health practitioners are required to respect a third party's confidentiality and may need permission to disclose relevant information.

In situations where the patient lacks capacity to make a decision, the guidelines in [section 2.1 What is different for adults who lack capacity to make informed decisions](#) and [section 3 Informed decision-making and consent for children and young persons](#) of this guide are followed.

5.4.3 Declining consent/discharge against medical advice

Where an Aboriginal and Torres Strait Islander patient declines to consent to a specific form of healthcare, or leaves the health facility, the general principles in [section 1.9 Can a patient or decision-maker decline or withdraw consent to healthcare?](#) apply.

The reasons for the patient's decision are checked carefully, because:

- it might be influenced by knowledge of a family member who died in the hospital
- they may be doing so simply in order to work through the process of coming to a decision, for example, consulting those important to them
- they may be willing to consent to healthcare but unwilling to signing the consent form because they are fearful of how it might be used and who might see it (health practitioners should explain clearly the purpose of the form and how it will be disclosed and retained).



Definition of terms

| Term | Definition | Source | See also |
|--------------------------|--|--|-----------------------|
| Adult | A person who is 18 years of age or older. | | |
| Advance Health Directive | <p>A document written by an adult who has capacity, which formalises their wishes about future health matters. It may also nominate one or more persons to make decisions on their behalf should they become unable to do so (a health attorney). It is only effective when that adult lacks capacity.</p> <p>A valid Advance Health Directive has the same effect as if the patient gave the directions when they had capacity.</p> | <p><i>Powers of Attorney Act 1998</i> (Qld) s35</p> <p><i>Guardianship and Administration Act 2000</i> (Qld) sch 4</p> | |
| Capacity | <p>Capacity is specific to a particular decision and means the health practitioner has assessed the person is capable of:</p> <p>‘(a) understanding the nature and effect of decisions about the matter; and</p> <p>(b) freely and voluntarily making decisions about the matter; and</p> <p>(c) communicating the decisions in some way.’</p> <p>It also includes the health practitioner’s assessment of the patient’s ability to retain the information and process it to reach a decision.</p> | <p>Schedule 3</p> <p><i>Powers of Attorney Act 1998</i> (Qld)</p> <p>Schedule 4</p> <p><i>Guardianship and Administration Act 2000</i> (Qld)</p> | |
| Child | An individual under the age of 18 years who may or may not have sufficient maturity and understanding to have capacity to make important decisions about healthcare. | <i>Child Protection Act 1999</i> (Qld) s8 | Minor Young person |
| Clinical incident | <p>Any event or circumstance which has actually, or could potentially, lead to unintended and/or unnecessary mental or physical harm to a patient.</p> <p>Clinical incidents include adverse events (harm caused) and near hits/misses (no harm caused).</p> | <p>Queensland Health Clinical Incident Management Implementation Standard (2009)</p> <p>http://www.health.qld.gov.au/qhpolicy/docs/imp/qh-imp-012-1.pdf [Online: accessed 19 January 2012]</p> | |

| Term | Definition | Source | See also |
|--|---|--|--|
| Clinical Incident Management System – PRIME CI | The Queensland Health electronic clinical incident management information system that records any event or circumstance which has actually, or could potentially, lead to unintended and/or unnecessary mental or physical harm to a patient of a Queensland Health service. | | |
| Clinician | A health practitioner, trained as a health professional, providing direct clinical care. Clinicians include registered and non-registered practitioners, or a team of health professionals. | National Safety and Quality Health Service Standards, June 2011 | |
| Competence | A legal term meaning that the patient has the capacity to make a particular decision. | | Capacity Gillick competence |
| Decision-maker | The patient or other person with the authority to make a decision whether to consent to or decline healthcare. For adults, substitute decision-makers are defined in the <i>Guardianship and Administration Act 2000</i> (Qld). For minors, the decision-maker will be a parent or guardian as defined in the <i>Family Law Act 1975</i> (Cwlth) or appointed under the <i>Child Protection Act 1999</i> (Qld) Refer also to ‘Substitute Decision-maker’ | <i>Guardianship and Administration Act 2000</i> (Qld) s12 <i>Family Law Act 1975</i> (Cwlth) s4 <i>Child Protection Act 1999</i> (Qld) s61 | Substitute Decision-maker |
| Delegate | Refer to ‘Health practitioner delegate’. Treating health practitioner | | Treating health practitioner Health practitioner delegate |
| Dental practitioner | Dental practitioners include dentists, dental specialists, dental therapists, oral health therapists, dental hygienists and dental prosthetists | | |
| Dental treatment | Refer to ‘Healthcare ‘ | | Healthcare |
| Doctor | Refer to ‘Medical practitioner’ | | Medical practitioner |

| Term | Definition | Source | See also |
|--|---|---|------------|
| Enduring Power of Attorney | A document through which an adult patient with capacity may authorise one or more persons to make decisions on their behalf at times when they do not have capacity to do so for themselves in the future. | <i>Powers of Attorney Act 1998</i> (Qld) s32 | |
| Ensuring Correct Patient, Correct Site and Side, Correct Procedure (3cs) | Ensuring that a surgical or other procedure/s is performed on the correct patient, on the correct side, and the correct site, and, if applicable, with the intended implant. | Queensland Health Ensuring Correct Patient, Correct Site and Side, Correct Procedure (3Cs) Policy http://qheps.health.qld.gov.au/psq/3cs/docs/3cs-policy.pdf (3Cs) Implementation Standard - http://qheps.health.qld.gov.au/psq/3cs/docs/3cs-standard.pdf [Online: accessed 16 November 2011] | |
| Examination | Refer to 'Healthcare '. | | Healthcare |
| Gillick competence | When a minor has the capacity to consent to healthcare, despite being under 18 years of age. To be Gillick competent, the minor must have sufficient understanding, intelligence and maturity to appreciate the nature of the healthcare, the consequences and risks of the healthcare that is proposed and the alternatives, including the consequences of not receiving the healthcare. This will vary according to the significance of the decision and factors within the child such as their maturity. | Gillick v West Norfolk and Wisbech Area Health Authority. [1986] 1 AC 112 (HL). | |
| Health literacy | Degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. | | |

| Term | Definition | Source | See also |
|------------------------------|--|--------|--|
| Health practitioner | <p>All health professionals who have the appropriate accreditation, authority and expertise to assist patients in the process of informed decision-making.</p> <p>Some examples include those persons registered as: medical practitioners, dental practitioners, nurses, pharmacists, physiotherapists and radiographers. Some other healthcare professionals who are unregistered and who have the authority and expertise include social workers, dieticians, Aboriginal and Torres Strait Islander health workers and linguistic interpreters.</p> <p>Depending on the circumstances, the health practitioner might be the treating health practitioner with overall responsibility for the care of a patient, but on other occasions may be acting as the health practitioner delegate.</p> | | <p>Treating health practitioner</p> <p>Health practitioner delegate</p> <p>Australian Health Practitioner Regulation Agency (www.ahpra.gov.au) [Online: accessed 16 November 2011]</p> <p>Office of Health Practitioner Registration Boards (OHPRB) (www.healthregboards.qld.gov.au) [Online: accessed 16 November 2011]</p> |
| Health practitioner delegate | <p>Refers to the delegate of the treating health practitioner, whom the treating health practitioner has deemed capable of assisting patients in the process of informed decision-making on their behalf. On a specific occasion, this might include a junior medical practitioner, radiographer, physiotherapist, registered nurse, nurse practitioner, oral health or dental therapist.</p> | | <p>Delegate</p> |

| Term | Definition | Source | See also |
|------------|--|---|--|
| Healthcare | <p>The term healthcare includes any care, or a service or a procedure, to diagnose, maintain or treat a patient’s physical or mental condition. For example,</p> <ul style="list-style-type: none"> • administration of a drug or other like substance including chemotherapy • any physical examination of a patient • dental or oral health examinations and treatment • psychological assessment • interventions such as blood transfusions • ‘invasive procedures’ as defined above, including surgical operations; oral health interventions • pathological and radiological investigations or procedures, for example, taking a blood sample or biopsy for analysis or radiotherapy • screening undertaken for pathological conditions, for example, breast or bowel cancer • services provided by the allied health disciplines; community and primary health services, such as assessment and screening programs • clinical trials or medical research. <p>Health care, of an adult, includes withholding or withdrawal of a life-sustaining measure for the adult, if the commencement or continuation of the measure for the adult would be inconsistent with good medical practice.</p> | <p><i>Guardianship and Administration Act 2000</i> Schedule 2 s5(2)</p> | <p>Dental treatment Medical treatment Invasive procedure</p> |
| Impairment | <p>Means a cognitive, intellectual, neurological or psychiatric impairment.</p> | | |

| Term | Definition | Source | See also |
|--------------------|---|--|------------|
| Informed consent | <p>For consent to be informed, the patient or decision-maker needs to be fully aware and have an understanding of the condition, the nature and purpose of the available and proposed healthcare, and the potential consequences of each option. Furthermore, the patient should be aware of what is likely to occur should they choose not to receive the healthcare.</p> <p>This results from a process of shared decision-making and the provision of information in a manner appropriate to the needs of an individual patient or decision-maker.</p> | | |
| Invasive procedure | <p>‘A procedure involving the insertion of an instrument, appliance or other object into human tissue, organs, body cavities or body orifices. Some examples include subcutaneous and intramuscular injections, blood collections, dentistry, suturing of superficial wounds and examinations of mouth’.</p> <p>It also includes such investigations as endoscopy and rectal or vaginal ultrasound.</p> <p>Refer to ‘Healthcare’</p> | <i>s147 Public Health Act 2005 (Qld)</i> | Healthcare |
| Legal guardian | A person appointed under the <i>Family Law Act 1975</i> (Cwlth) or appointed under the <i>Child Protection Act 1999</i> (Qld) who has the legal authority to consent on behalf of a child or young person. | <i>Family Law Act 1975</i> (Cwlth) <i>Child Protection Act 1999</i> (Qld) s61 | |
| Material risk | <p>Within this suite of documents, ‘material risk’ refers to the information about the risks of healthcare that</p> <ul style="list-style-type: none"> • a reasonable person in the patient’s position would, in the circumstances, require to enable the person to make a reasonably informed decision about whether to receive the healthcare or follow the advice; and • the health practitioner knows or ought reasonably to know the patient wants to be given before making the decision about whether to receive the healthcare. | <p>Adapted from</p> <p>Rogers v Whittaker (1992) 175 CLR 479 (High Court of Australia)</p> <p>s. 21 <i>Civil Liability Act 2003</i> (Qld)</p> <p>NB the Act and the case impose duties on doctors.</p> | |

| Term | Definition | Source | See also |
|----------------------|---|---|--|
| Medical officer | Refer to 'Medical practitioner' | | Medical practitioner |
| Medical practitioner | A person registered as a medical practitioner by the Medical Board of Australia, and, within this guide includes other descriptions such as 'doctor' and 'medical officer'. | | Refer to section 1.12 Who is responsible for obtaining patient consent in an environment of shared care and multi-disciplinary teams? |
| Medical treatment | Refer to 'Healthcare ' | | Healthcare |
| Minor | An individual under the age of 18 years. | <i>Child Protection Act 1999 (Qld) s8</i> | Young person |
| Midwife | A person registered and licensed as a midwife by the Nursing and Midwifery Board of Australia | | Refer to section 1.12 Who is responsible for obtaining patient consent in an environment of shared care and multi-disciplinary teams? Health practitioner |
| Nurse Practitioner | A person registered and licensed as a registered nurse and holding an additional endorsement as a nurse practitioner from the Nursing and Midwifery Board of Australia. | | Refer to section 1.12 Who is responsible for obtaining patient consent in an environment of shared care and multi-disciplinary teams? Health practitioner |
| Nurse | A person registered and licensed as a registered or enrolled nurse by the Nursing and Midwifery Board of Australia | | Health practitioner |
| Open access | The open access system allows a health practitioner to directly schedule elective procedures for patients without them having first been examined by a specialist proceduralist. Examples might include endoscopy, colonoscopy and radiological procedures. | | |

| Term | Definition | Source | See also |
|-----------------------------|---|---|----------------|
| Parent | <p>Means a person with parental responsibility for a child or young person, such as a natural parent, adoptive parent, guardian, or someone who is subject of a parenting order for the child under the <i>Family Law Act 1975</i> (Cwlth).</p> <p>More than one person may have parental responsibility.</p> | <i>Family Law Act 1975</i> (Cwlth) s4 | Parent |
| Patient | <p>The term ‘patient’ refers to the patient or other person who is legally able to make a decision on behalf of the patient.</p> <p>In relation to the informed consent process, a person who is legally recognised as an appropriate decision-maker for a patient who lacks capacity is treated in the same as the patient.</p> <p>For a child or young person this might be a parent or legal guardian.</p> <p>For an adult this might be a substitute decision-maker as defined within the <i>Guardianship and Administration Act 2000</i> (Qld).</p> <p>Synonyms for ‘patient’ include client or customer</p> | | Decision-maker |
| Patient-centred care | <p>The delivery of healthcare that is responsive to the needs and preferences of patients. Patient-centred care is a dimension of safety and quality.</p> <p>The dimensions of patient-centred care are respect, information and communication, education, emotional support, physical comfort, continuity and transition, care co-ordination, involvement of family and carers, and access to care.</p> | National Safety and Quality Health Service Standards, June 2011 | |
| Procedure | A component of healthcare. | | Healthcare |
| Sight translation | Rendering a verbal interpretation of a written message (reading in one language, relaying messages orally in another language). | | |
| Special Access Scheme (SAS) | This scheme allows medical practitioners to prescribe medications which are not approved for use in Australia on a case-by-case, individual patient basis, where certain conditions have been met. | Therapeutic Goods Administration www.tga.gov.au/hp/index.htm [Online: accessed 16 November 2011] | |

| Term | Definition | Source | See also |
|-----------------------------|---|--|---------------------------|
| Special healthcare matter | <p>Healthcare of the following type:</p> <ul style="list-style-type: none"> removal of tissue from a patient while alive for donation to someone else sterilisation termination of a pregnancy participation in special medical research or experimental healthcare electroconvulsive therapy or psychosurgery care prescribed under the <i>Guardianship and Administration Act 2000</i> (Qld). | <i>Guardianship and Administration Act 2000</i> (Qld) sch 2, 5.7 | |
| Statutory Health Attorney | <p>The first person from the following list (in descending order or priority) who is readily available and culturally appropriate to make a decision on the current matter:</p> <ul style="list-style-type: none"> a spouse of the adult patient if the relationship is close and continuing | <i>Powers of Attorney Act 1998</i> (Qld) - s62 - 63 | Substitute-decision-maker |
| Statutory Health Attorney | <ul style="list-style-type: none"> a person who is 18 years or over and who has the care of the adult patient (but not a paid carer for the adult). This includes someone who provides or arranges domestic services and support to the adult. Where a patient resides in an institution the patient remains in the care of the person in whose care they were immediately before residing in the institution a person who is 18 years or over and who is a close friend or relation of the adult patient and is not a paid carer for the adult; or, if no other substitute decision-maker is readily available and culturally appropriate to exercise power for a matter, the adult guardian. | | |
| Student health practitioner | Someone enrolled in an approved program of study. | | Trainee |

| Term | Definition | Source | See also |
|-------------------------------|--|--------|--|
| Substitute decision-maker | The person who is legally entitled to give consent to healthcare on behalf of a patient who lacks capacity. This may be a guardian, or attorney under an Advance Health Directive or Enduring Power of Attorney or Statutory Health Attorney. Refer also to 'Decision-maker' | | Decision-maker |
| Trainee health practitioner | Someone enrolled in an approved program of study. | | Student |
| Treating health practitioner | The health practitioner with overall responsibility for the care of a patient. In many instances this will be the treating medical practitioner but may be another health practitioner with responsibility for the patient, for example, a midwife working within the Queensland midwifery models of care. | | Treating medical practitioner Refer to section 1.12 Who is responsible for obtaining patient consent in an environment of shared care and multi-disciplinary teams? |
| Treating medical practitioner | Refers to the specialist/consultant under whose care the patient is admitted or the specialist/consultant to whom the patient is referred for healthcare. | | Treating health practitioner Refer to section 1.12 Who is responsible for obtaining patient consent in an environment of shared care and multi-disciplinary teams? |
| Treatment | A form of healthcare. | | Healthcare |
| Young person | An individual under the age of 18 years who may or may not have sufficient maturity and understanding to have capacity to make important decisions about healthcare. | | Minor Child |

Appendix 1 Useful contact details

Aboriginal and Torres Strait Islander Health Branch (A&TSIHB)

| | |
|-----------------|---|
| Postal address: | GPO Box 48, Brisbane QLD 4001 |
| Phone: | (07) 323 40760 |
| Facsimile: | (07) 323 41756 |
| Website: | http://qheps.health.qld.gov.au/atsihb/home.htm www.health.qld.gov.au/atsihealth/ |
| Email: | DATSIHU@health.qld.gov.au |

Commission for Children and Young People and Child Guardian

| | |
|-----------------|--|
| Postal address: | PO Box 15217, Brisbane City East |
| Phone: | (07) 3211 6700 |
| Facsimile: | (07) 3247 5507 |
| Website: | www.ccypcg.qld.gov.au |
| Email: | info@ccypcg.qld.gov.au |

Department of Communities (Child Safety)

| | |
|-----------------|--|
| Postal address: | GPO Box 806, Brisbane QLD 4000 |
| Freecall: | 1800 811 810 (Queensland only) |
| Phone: | (07) 3224 8045 |
| Website: | www.childsafety.qld.gov.au/ |
| Email: | info@childsafety.qld.gov.au |

Queensland Civil and Administrative Tribunal (QCAT)

| | |
|-----------------|--|
| Postal address: | GPO Box 1639, Brisbane QLD 4001 |
| Phone: | 1300 753 228 or (07) 3012 2500 |
| Facsimile: | (07) 3221 9156 |
| Website: | www.qcat.qld.gov.au |
| Email: | enquiries@qcat.qld.gov.au |

Interpreter Service

The Queensland Health website has contacts for District Interpreter Coordinators and Area Health Service Interpreter Quality Officers

Website: www.health.qld.gov.au/multicultural

Email: multicultural@health.qld.gov.au

Mental Health Act Liaison Officer Mental Health Act Statutory Administration and Policy Unit

Phone: 1800 989 451

Website: <http://qheps.health.qld.gov.au/mhalu/>

Email: mhaz000@health.qld.gov.au

An online resource on the *Mental Health Act 2000* (Qld) can be found at http://qheps.health.qld.gov.au/mhalu/resource_guide.htm

Multicultural Health

Postal address: Division of the Chief Health Officer
Queensland Health
PO Box 2368
Fortitude Valley QLD 4006

Phone: 07 3328 9880

Website: www.health.qld.gov.au/multicultural

The Queensland Health website includes information about a wide range of health topics in many different languages. This includes material about the health system and services, training and education for staff and resources containing multicultural health information.

Email: multicultural@health.qld.gov.au

Office of the Adult Guardian

Postal address: PO Box 13554, Brisbane 4003

Phone: (07) 3234 0870 or 1300 653 187 (outside Brisbane)

Facsimile: (07) 3239 6367

Website: www.justice.qld.gov.au/guardianship

Email: guardianship@justice.qld.gov.au

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