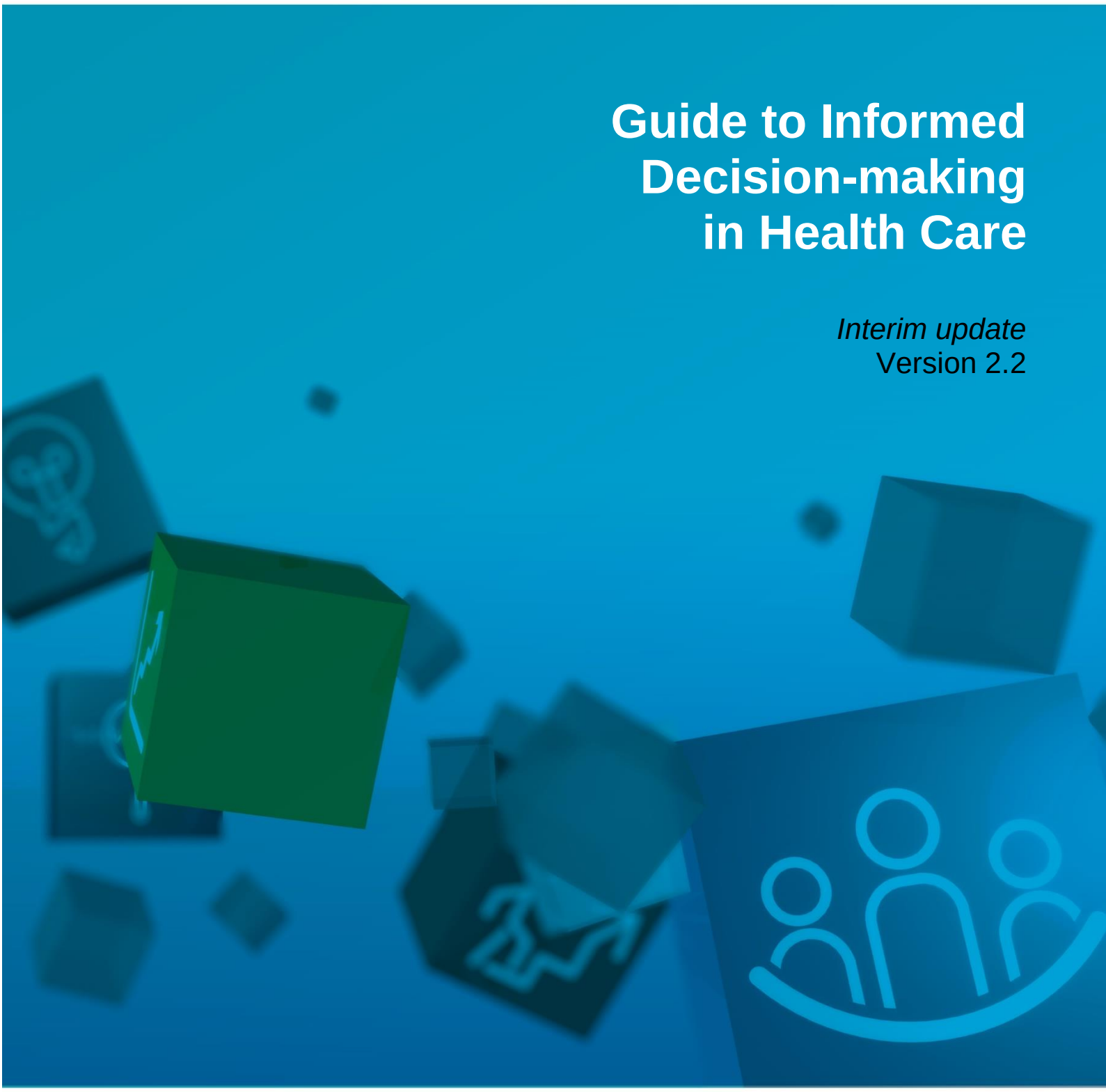
Queensland Health

Clinical **Excellence** Queensland

Guide to Informed Decision-making in Health Care

Interim update
Version 2.2



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Disclaimer

The *Guide to Informed Decision-making in Health Care* is currently under review. This interim version, 2.2, includes changes to align with the Queensland *Mental Health Act, 2016.* The changes are outlined in *Table 1, Version history*.

The information within the *Guide to Informed Decision-making in Health Care* 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 and check relevant legislations.

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Foreword

Patient-centred care is widely recognised as a core dimension of a quality modern health service. Fundamental to informed decision-making is 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. A well informed patient can actively participate in the decision-making process about their care, and better understand the likely or potential outcomes of their treatment. Informed decision-making also provides an additional layer of vigilance and protection against errors which may result in adverse events. Performed well, the informed decision-making process builds trust, prevents harm and reduces surprise and distress if complications or adverse events do occur.

The provision of informed consent by a patient reflects the end point of a process of engagement between the patient and at least one health practitioner who has provided information to the patient to assist making an informed decision in relation to their health care. While consent forms are often necessary for risk management, completing the form is the final step in documenting a patient's decision about consent; completing a consent form does not constitute the entire informed decision-making process.

This *Guide to Informed Decision-making in Health Care* (Guide) documents the broadening approach to informed patient decision-making in Queensland Health and is intended to be contemporaneous with and reflect the national and international ethical, medico-legal and service delivery environment as it evolves and relates 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.

Reflected within this Guide is the often complex ethical, legal, policy and practical framework of contemporary health care in which public sector health services are delivered. Such health care is delivered in a multidisciplinary team environment in which medical practitioners, dentists, nurses and other allied health practitioners, who each have differing roles and responsibilities in the provision of health care, provide care 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 and legislation.

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

This second edition of the Guide contains updates following the introduction of the *Hospital and Health Boards Act 2011* and the establishment of independent Hospital and Health Services. Each Hospital and Health Service has a Human Resource (HR) Unit who can provide further and specific advice around local process issues with respect to informed consent.

I would like to personally thank the staff of Patient Safety and Quality, Clinical Excellence Queensland, key clinical groups, consumers, legal advisors and other stakeholders for their contribution to the development and revision of this innovative Guide.

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Patient Safety and Quality Clinical Excellence
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Introduction

Background

Consistent with good clinical practice, the Queensland Health suite of informed consent documents support the rights of patients and their substitute decision-makers to:

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

Purpose

The Guide has been developed as a reference tool to support practitioners in understanding the complex ethical and legal requirements surrounding informed decision-making about health care. Where specific policies are referenced within the body of the Guide, the reader should confirm whether there are any Hospital and Health Service (HHS) local policies that apply.

The information contained in this document is intended to guide good clinical practice while recognising a need for flexibility for health professionals. This Guide does not take precedence over legal advice or other health 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, you should seek legal advice from either your HHS legal team or Legal Branch.

This Guide recognises that health care workers and patients have mutual rights and responsibilities concerning informed decision-making with health care. The patient's rights and responsibilities outlined in The Joint Commission's documents Speak Up series, including *Speak Up For Your Rights*[1] and *Speak Up About Your Care*[2], are supported within the framework of this document.

Various issues are beyond the scope of this Guide, such as the availability of health care and financial issues, including Medicare ineligible patients or overseas students without insurance or funds to pay for health care.

Division of the Guide

This Guide is divided into five 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 to make informed decisions.

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

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

Part 4 some health care 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

1 https://www.jointcommission.org/resources/for-consumers/speak-up-campaigns/for-your-rights/
2 https://www.jointcommission.org/resources/for-consumers/speak-up-campaigns/about-your-care/

- 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:

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

Part 1 The general informed decision-making process

1.1 What is health care?

In the Guide the words health care and treatment are interpreted broadly. These words encompass a range of activities related to the care and/or treatment of a patient and refer generally to the provision of a public sector health service including *diagnosing, maintaining, or treating the patient's physical or mental condition, carried out by, or under the direction or supervision of, a health provider*[3]. The following examples are considered health care within this document:

- administering a drug or other substance, including chemotherapy
- a physical examination of a patient
- dental or oral health examinations and treatment
- psychological assessment
- treatment of mental illness
- interventions such as blood and blood product transfusions
- invasive procedures, 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 the application 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 health care. 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 health care 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.

For the purposes of this Guide, consent means a person's agreement to the provision of public sector health services. Informed consent means that a patient has received the relevant information in a way they can understand, to enable them to make an informed decision and they have voluntarily given permission for the health care service to be provided. In an ethical sense, the agreement by a patient to receive public sector health services 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 health care offered.

For the patient's informed consent to health care to be valid, certain principles must be fulfilled[4]:

- 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

[3] *Guardianship and Administration Act 2000* (Qld), schedule 4 definition of 'health care'.

[4] Kerridge, I, Lowe, I and McPhee, J, *Ethics and law for the health professions,* (2005), 2nd edition, The Federation Press, Sydney pp 215 to 236.

- as far as possible, the patient is advised in simple terms of:
    - the diagnosis and possible or likely nature of the illness or disease
    - recommended health care, including the expected benefits, common adverse effects and alternative health care options
    - the material risks including complications associated with:
        - the recommended health care
        - alternative health care options
        - a decision not to receive the health care offered
    - any significant long term physical, emotional, mental, social, sexual or other expected outcomes
    - The degree of certainty of any diagnosis
    - The degree of certainty about the therapeutic outcome
    - Whether the health care is conventional or experimental
    - the anticipated recovery implications
- the patient has sufficient time to consider and clarify 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 health care provided.

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

See *Section 1.6: What process of informed decision-making needs to be followed?*

1.3 Why is it necessary to obtain consent?

Consistent with ethical and legal principles, it is a patient's right generally to decide what health care they wish to receive. As a matter of policy, no health care (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 health care or not, except when it can be shown – following an appropriate clinical assessment, the individual does not have the capacity to make a decision. This is discussed further in *Section 1.7: Is this adult patient able to make a decision about health care themselves?*

For young persons under the age of 18 years please refer to *Section 3: Informed decision-making for children and young persons* for comprehensive information.

Failure to obtain a patient's consent to health care may result in a criminal charge of assault or civil action for battery. In addition, to inform a patient exposes health practitioners to risks of legal claims for negligence[5]. In either case, disciplinary action by Queensland Health may be pursued.

1.4 What health care requires consent?

All health practitioners must obtain consent from an appropriate decision-maker before touching (examining) or providing health care to adult and child patients[6] 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?

[5] *Consent sent to Treatment Policy – 2023*, Department of Health Western Australia. https://www.health.wa.gov.au/~/media/Corp/Policy-Frameworks/Clinical-Governance-Safety-and-Quality/Consent-to-Treatment-Policy/Consent-to-Treatment-Policy.pdf

[6] This includes persons who are offenders (persons incarcerated in prison).

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 health care 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 health care, 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 health care.

Written consent

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

A 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 health care 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.

Written consent is advisable for:

- any health care which carries significant risks to the patient
- where doubt exists about the patient's capacity to consent
- where the health care 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 comprehensive documentation in the patient's clinical record that provides supporting evidence of the discussions held and the decision reached.

Queensland Health highly recommends that written consent be obtained for:

- all health care 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's individual 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 trials[7].

Where practice standards require written consent (for example, the Diagnostic Imaging Accreditation Scheme (DIAS) Practice Accreditation Standards January 2016 – Transvaginal Ultrasound); it should be noted that Queensland Health is supportive of such standards and recommends as best practice that written consent be obtained. Visit: https://www.safetyandquality.gov.au/standards/diagnostic-imaging/diagnostic-imaging-accreditation-scheme-standards

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 health care and has, where appropriate, supporting 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 practitioners[8].

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 proposed[9].

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

[7] Adapted from *Consent to Treatment Policy– 2023, Department of Health Western Australia.* https://www.health.wa.gov.au/~/media/Corp/Policy-Frameworks/Clinical-Governance-Safety-and-Quality/Consent-to-Treatment-Policy/Consent-to-Treatment-Policy.pdf

[8] *Patient-centred care: Improving quality and safety through partnerships with patients and consumers* (2011), Australian Commission on Safety and Quality in Health Care p21.

[9] Adapted from *Guidance on professional standards and ethics for doctors Decision making and consent,* 2020, General Medical Council https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors---decision-making-and-consent-english_pdf-84191055.pdf

- level of knowledge about, and understanding of, their condition, prognosis and the health care options[10].

During this interaction, if there is any evidence to suggest the patient might not have capacity to provide consent to the particular health care 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 health care 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) have published detailed guidance to medical practitioners on communicating with patients, and the minimum level of information provided to patients[11]. 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
- be well balanced
- be 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 relevant public sector health service or not. Consistent with good clinical practice, it is recommended that health practitioners provide – in simple, non-medical jargon terms – the information a reasonable patient (or decision-maker) requires, so they can make a reasonably informed decision about the health service and/or health care 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[12] [13].

Following the discussions, the patient should demonstrate they understand, in simple, non-medical jargon terms[14](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 may reduce this
- the options for investigating, managing or treating the condition, and for each option:
    - what the proposed health care involves including its purpose, nature and complexity
    - the potential benefits and likelihood of success
    - the potential complications, risks, 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

[10] Adapted from *Guidance on professional standards and ethics for doctors Decision making and consent,* 2020, General Medical Council https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors---decision-making-and-consent-english_pdf-84191055.pdf

[11] *Guidelines for Medical Practitioners on Providing Information to Patients* (2004); and *Communicating with Patients: Advice for Medical Practitioners (*2004), National Health and Medical Research Council (NHMRC).

[12] Adapted from *Rogers v. Whittaker* (1992) 175 CLR 479 and *Civil Liability Act 2003* (Qld) - Section 21.

[13] Refer to Background to this suite of documents.

[14] *Guidelines for Medical Practitioners on Providing Information to Patients* (2004), National Health and Medical Research Council (NHMRC).

- the time involved in the health care, 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 health care
- 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 health care, 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 known 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[15] [16]

The health practitioner will need to obtain a sufficiently detailed history about the patient so the information provided to the patient can be tailored to their individual circumstances.

The extent of the discussions may vary with[17]:

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

For a patient, consumer or a resident who has a substitute decision maker, an enduring Power of Attorney or a Statutory Health Attorney, the decision maker is to be given the same information as would be expected to be given to the person if they were providing consent for themselves. Details of the consenting individual and any legal instruments should be documented in the appropriate section of the consent form.

For health care without significant risk to the patient the discussions may not be as extensive *(*see *Section 1.6.7: Documenting the consenting process).* For complex health care interventions, those with greater risks or more uncertainty, and non-therapeutic or research interventions, the discussions may be more wide-ranging.

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

[16] Refer to the Background Section to this suite of documents.

[17] *Guidelines for Medical Practitioners on Providing Information to* Patients (2004), National Health and Medical Research Council (NHMRC).

1.6.4 Presenting information

Patients feel engaged with their care when they make decisions based on information provided in a form and manner that clearly identifies the issues and health care 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[18]
- using ways to present information appropriate to that individual's needs, including diagrams, printed, video or aural materials and media
- including a support person, for example a partner, family or significant other person
- engaging the services of an interpreter if English is not the patient or decision-maker's first language (see *Section 5.1: What about patients who have additional communication needs?)*
- for persons receiving treatment and care for mental illness, working with an Independent Patient Rights Adviser and/or the person's Nominated Support Person
- asking for the assistance of an Indigenous Hospital Liaison Officer if the patient is of Aboriginal and/or Torres Strait Islander origin.

See *Section 5.4: What are the consent issues for Aboriginal and Torres Strait Islander patients?* for additional details.

It is recommended that the specific details regarding the use of additional resources (for example, type of media, title, publisher, and 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.

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 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 a patient's age, the severity or complexity of the disease or condition, the effects of medication, the impact of distress or trauma 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.

[18] *Guidelines for Medical Practitioners on Providing Information to Patients* (2004), the National Health and Medical Research Council (NHMRC).

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 Confirming the patient has understood the information provided

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

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

If a health care practitioner is concerned a patient or decision-maker does not understand the health care options well enough to make an informed decision, the practitioner should take reasonable steps to ensure they receive the necessary information before health care 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 (see *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 recommended the health practitioner ensures the patient or decision-maker understands the situation by clearly stating they agree to a particular form of health care (for example, examination, assessment, investigation, procedure or treatment).

1.6.7 Documenting the consenting process

Consent to health care without significant risks to the patient does not require a written consent form. However, the nature of the health care 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 cannula
- requesting blood tests
- abdominal ultrasound
- urethral catheterisation
- dressings
- child and/or adult health check
- information sharing.

Invasive treatments and health care with significant risks

Queensland Health highly recommends the documenting of informed consent using an approved Queensland Health consent form for all private and public patients treated in Queensland Health facilities. This ensures state-wide standardisation and minimises potential risks to patients.

A diverse range of patient information sheets and procedure specific consent forms are accessible through Queensland Health Patient Safety and Quality, Clinical Excellence Queensland: https://www.health.qld.gov.au/consent. Some of the more common patient information sheets are available in different languages.

These procedure specific forms have been designed as an aid 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 health care and the risks involved in the proposed health care.

In situations where a procedure specific consent form is not available, the generic consent form can be used. Some types of health care do not have a state-wide document because they are low volume or are only provided in a limited number of facilities. For example, certain physiotherapy treatment plans or specific foetal-maternal procedures conducted only at the Royal Brisbane and Women's Hospital. As an alternative to the state-wide generic form, a Hospital and Health Services (HHS)-specific consent form may be used, providing this form has passed through a governance process including an HHS 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 should 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 that the risks were discussed with the patient[19]. The following information in relation to the patient should be documented clearly:

- patient's full name, date of birth and UR Number (if available)
- the condition
- substitute decision maker/s present
- the health care service to be performed, including the side and site of any treatment or procedure
- the material risks and benefits of the proposed health care and/ or withheld treatment discussed for that individual patient
- date and time of discussion/s, any concerns raised, and decisions for/against
- date and time when the consent was recorded, noting substitute decision-maker/s when applicable
- any patient aids or diagrams provided (including a copy of the particular version of any printed materials)
- documentation of consent to treatment/withholding of treatment by relevant decision-makers
- the full name, title and the signature of the health practitioner obtaining the consent.

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 health care 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[20] 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 *Research management- Department of Health Standard (QH-IMP-013-1:2022),* Queensland Health outlines the consent requirements to be obtained from participants.

Visit: https://www.health.qld.gov.au/system-governance/policies-standards/doh-policy/

The use of abbreviations

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

- fingers are to be identified by name and not number, that is, thumb, index, middle, ring and little finger
- the health care (procedure) is to be written in full. For example Right instead of R or Rt.

1.6.8 Consent documentation and patient transfer

When transferring a patient to another facility, the original written consent document for the proposed health care should, where possible, accompany the patient to the facility where the health care is to be provided. If this is not possible in the circumstances, a faxed or scanned copy of the original consent form may be forwarded to the treating facility.

A copy of the consent form should be retained in the patient's clinical record at the referring facility.

In facilities where clinical electronic records are in use, appropriate practices that comply with relevant policies and procedures regarding electronic records must be followed.

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

1.6.9 Retention of consent documentation

To ensure compliance with the *Public Records Act 2002*, all signed consent forms and any supplementary documents are to be filed in the patient's 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 the '*Health Sector (Clinical records) Retention and Disposal Schedule*' and the '*Retention and disposal of clinical records Standard QH-IMP-280-1.2014'*.

Visit: https://www.forgov.qld.gov.au/__data/assets/pdf_file/0019/203581/Health-Sector-Clinical-Records-Retention-and-Disposal-Schedule.pdf and https://www.health.qld.gov.au/__data/assets/pdf_file/0026/397223/qh-imp-280-1.pdf

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

[20] At the time of publication this is the *Indemnity for Queensland Health Medical Practitioners* - Human Resources Policy I2 (QH-POL-153). (2020)

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 the 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)
- 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 Section 63(4) of the *Guardianship and Administration Act 2000* (Qld) when providing urgent health care, or when administering a blood transfusion to a child without consent under Section 20 of the *Transplantation and Anatomy Act 1979 (Qld)*
- additional information consistent with good practice, or professional standards or codes of professional conduct.

Where, for example, 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 health care themselves?

This section is based on the *Queensland Health, Withholding and withdrawing life-sustaining measures Legal considerations for adult patients* and the *Care Plan for the Dying Person Health Professional Guideline*[21], the reader is referred to the original for more detailed discussion. (Intranet Queensland Health staff only).

All adults are presumed to have capacity to decide whether they wish to receive health care or not, except when it can be shown they lack capacity.

Under Queensland legislation[22a] 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.

Additionally, the *Mental Health Act 2016*[22b] also defines capacity for the purposes of consent to treatment. This is covered in *Section 4.2* of this Guide.

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[23] to:

- express a choice
- understand information relevant to health care decision-making
- appreciate the significance of that information for their own situation, especially concerning their illness and the probable consequences of their health care options
- use relevant information to reason so as to engage in a logical process of weighing up the health care 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 with which the health practitioner disagrees. Health practitioners work on the presumption that every adult patient has the capacity to decide whether to agree to or decline health care (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.

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21 Queensland Health, *Withholding and withdrawing life-sustaining measures: Legal considerations for adult patients* https://www.health.qld.gov.au/__data/assets/pdf_file/0038/688268/measures-legal.pdf https://clinicalexcellence.qld.gov.au/sites/default/files/docs/clinical-pathways/care-plan-dying-person/care-plan-dying-person-health-professional.pdf

22 a) Schedule 3 of the *Powers of Attorney Act 1998* (Qld) and Schedule 4 of the *Guardianship and Administration Act 2000* (Qld)

22 b) *Mental Health Act 2016* (Qld)

23 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 [Intranet Queensland Health staff only].

Consideration should be given as to whether the patient has capacity to consent to or decline health care 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 suitably qualified and experienced medical practitioner such as a geriatrician, psychiatrist or neurologist is suggested.

Simply because a patient makes a decision with which a health practitioner disagrees, 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 health care and the specific time taking into account the patient's circumstances and the health care proposed.

Appendix 2: Assessing decision-making capacity of the Queensland Health *Care Plan for the Dying Person Health Professional Guidelines* https://clinicalexcellence.qld.gov.au/sites/default/files/docs/clinical-pathways/care-plan-dying-person/care-plan-dying-person-health-professional.pdf 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:
    - 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 who have a mental illness (including those who may be subject to involuntary provisions of the *Mental Health Act 2016*) may still have capacity to make decisions about certain aspects of their health care, and an assessment of their capacity on a specific issue at a specific time should be made, as above (see also *Section 4.2: Considerations for persons receiving treatment and care under the Mental Health Act 2016*).

For further information, refer to the Queensland Health *Care Plan for the Dying Person Health Professional Guidelines* https://clinicalexcellence.qld.gov.au/sites/default/files/docs/clinical-pathways/care-plan-dying-person/care-plan-dying-person-health-professional.pdf and *Withholding and withdrawing life-sustaining*

measures: Legal considerations for adult patients.
https://www.health.qld.gov.au/__data/assets/pdf_file/0038/688268/measures-legal.pdf

1.7.1 Supported decision-making

Supported decision-making can be simply defined as a model for supporting people with disabilities to make significant decisions and to exercise their legal capacity.

Information regarding supported decision-making can be found in the 2016 report: *Decision-making support and Queensland's guardianship system released by the Office of the Public Advocate* https://www.justice.qld.gov.au/__data/assets/pdf_file/0010/470458/OPA_DMS_Systemic-Advocacy-Report_FINAL.pdf

This report highlights the opportunities that exist for Government to take the lead on the issue of supported decision-making and support people with impaired decision-making capacity to be autonomous to the greatest extent possible.

1.8 What if there is doubt about a patient's capacity to give consent or their capacity 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 health care, 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 health care 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 health care 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[24]:

- if the clinical condition allows, deferring the health care 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—see *Section 2.2: Who can consent for adult patients who have impaired capacity?:Substitute decision-makers.*

[24] Modified from *Guidance on professional standards and ethics for doctors Decision making and consent,* 2020, General Medical Council https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors---decision-making-and-consent-english_pdf-84191055.pdf

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

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

A patient may also change their mind or withdraw consent at any time. For example, they may want to delay all or part of their treatment. Declining or withdrawing of consent can be done 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 health care 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
    - any cultural or religious conflict that the patient may have
- exploring other health care options that might be acceptable to them.

Where necessary, provide further explanation of the health care 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 health care 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 health care 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 health care, and any known reasons, are 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 health care team
- the decision was contrary to best interests of the patient[25]
- 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 health care, 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 health care simply because they might decide to decline the health care, 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.

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 information[26] may not be sufficient to overcome the obligations to disclose information arising from the *Civil Liability Act* 2003 in Queensland (see *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 must be documented in the patient's clinical record.

1.10.2 The patient does not wish to be given information [27] [28]

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

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[25] *Guardianship and Administration Act 2000,* Schedule 1.

[26] *General Guidelines for Medical Practitioners on Providing Information to Patients* (2004) p12, the National Health and Medical Research Council (NHMRC)

[27] Adapted from *Guidance on professional standards and ethics for doctors Decision making and consent,* 2020, General Medical Council https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors---decision-making-and-consent-english_pdf-84191055.pdf

[28] *Communicating with Patients: Advice for Medical Practitioners* (2004) p11, the National Health and Medical Research Council (NHMRC*)*

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 health care. This is likely to include:

- what the health care aims to achieve
- what the intervention will involve. For example:
    - whether the health care 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 health care
    - whether it involves any serious risks.

The health practitioner can also:

- consider whether the patient's decision arises due to language or cognitive difficulties, cultural issues or the impact of trauma and/or distress and whether an interpreter or specialist support person should be used
- consider whether it may be appropriate to defer the health care 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 health care 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.

Legal advice should be sought if the patient's decision is to decline information and their health care:

- 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 health care 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 health care:

- 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) and that care is taken to ensure that changing circumstances do not threaten the validity of the consent that has been given
- there has been no significant change in the nature of intended health care 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
- that such consent is limited to treatment for a single health care matter or a course of treatment to treat a specific health care matter

The same applies where consent is limited to a single pregnancy during which multiple (invasive, transvaginal) ultrasound scans will be performed to monitor maternal and/or foetal health.

The health practitioner (see *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 health care 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 health care or the options available. Evidence of the review is appropriately documented in the patient's clinical record (see *Section 4.3: Blood and blood products transfusion*).

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 health care 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 health care being provided.

As members of the team providing health care 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 the 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 practice scope and model of care agreed locally. In some situations, a health practitioner may be acting autonomously in the diagnosis and treatment of a patient, 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 health care 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 health care 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 health care and any alternatives
- a patient or decision-maker has given valid informed consent prior to the health care being provided
- relevant evidence of the consent is appropriately documented.

For example, a surgeon may refer a patient to a stomal therapist to receive more information about a stoma which would result as part of a proposed surgical procedure. The stomal therapist may meet with the patient and their carer and provide detailed information which the patient would consider when making a decision. The stomal 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 health care, the health practitioner recommending or providing the health care (for example, a registered nurse or radiographer) is usually the person responsible for ensuring the patient understands the proposed health care and consents either verbally or through their actions. The health practitioner is also responsible for ensuring that the consent is appropriately documented (see *Introduction*).

It should be noted that low risk medical imaging examinations do not require written consent. However, they do require that express verbal consent is given prior to the examination (that is: implied consent is not sufficient) and that this is recorded on the request form or within the electronic medical record. The health practitioner responsible for obtaining (or delegating) express verbal consent is the health practitioner who signs as team leader for the purposes of completing the 'Final Check' (refer to HHS HR Unit for local procedures) and see *Section 1.4.2: Implied consent* and *Section 1.4.2: Explicit/express consent* for further information.

For those specific forms of health care 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

(Refer to the Glossary for the difference between health practitioner and medical practitioner).

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

- the 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 health care to be provided and is sufficiently knowledgeable about the health care 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 health care 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 is responsible for:

- recognising and working within the limits of their professional competence and defined scope of practice
- carrying out the task in order to fulfil their legal and professional responsibilities to obtain valid, informed consent
- ensuring any consent form is completed and the consent appropriately documented in the patient's clinical record
- documenting their name and position legibly on the consent form and in the clinical record
- declining 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 health care to be provided

- notifying 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 health care provision to another health practitioner, the delegate applies the principles of informed consent prior to providing the health care. 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 health care is to be provided or performed by a medical practitioner, the task of informing a patient about the material risks of the health care, 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

(Refer to the Glossary for the difference between health practitioner and medical practitioner).

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 senior medical practitioner 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 required 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 health care provision to another health practitioner, the delegate applies the principles of informed consent prior to providing the health care. 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 health care 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 health care, the senior medical practitioner remains responsible, as detailed in *Section 1.12.2: Health practitioners and delegation*.

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 healthcare practitioners who 'have successfully completed the prescribed course of studies in midwifery and acquired the requisite qualifications to be registered by the Nursing and Midwifery Board of Australia to practice midwifery'.[29]

"The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures"(Nursing and Midwifery Board of Australia—NMBA—2006). https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx
Midwives work in a variety of metropolitan, rural or remote locations and practise in a number of different settings including the home, community, hospitals, clinics or health units (International Confederation of Midwives—ICM—2005).

Midwives are expected to meet the standards described in this Guide when assisting patients or decision-makers to make informed decisions about health care 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 health care they provide, acting within the limits of their individual competence, 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. Nurse practitioners are endorsed in Australia pursuant to Section 95 of the *Health Practitioner Regulation National Law Act* 2009 (Qld) 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 health care. 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 health care they provide, acting within the limits of their individual competence[30] and specific defined scope of practice determined by the context in which they are authorised to practice[31].

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[29] *Code of Ethics for Midwives in Australia* (2008) – Australian Midwifery Council – Approved by the Nursing and Midwifery Board of Australia https://www.nursingmidwiferyboard.gov.au/documents/default.aspx?record=WD10%2F1354&dbid=AP&chksum=5Rlk27NSaS9n%2F%2BtvoYxT2w%3D%3D

[30] A nurse practitioner's competence in relation to the health care they are performing shall be assessed within the framework of the national registration standard and *Nurse practitioner standards for practice* published by the Nursing and Midwifery Board of Australia https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/nurse-practitioner-standards-of-practice.aspx

[31] *Nurse practitioner standards for practice* (2021), Published by the Nursing and Midwifery Board of Australia https://www.nursingmidwiferyboard.gov.au/documents/default.aspx?record=WD18%2f25281&dbid=AP&chksum=kYbO0%2bO7kx9l%2fBlvmKH%2bwg%3d%3d

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 health care 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 health care. This means ensuring:

- consent given by the patient is free from undue influence and social coercive influences
- 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 health care to them and that in declining the involvement of a trainee/student in their presence would not be detrimental to the patients care
- 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.

1.12.7 Visitors to the operating theatre

"Visitor" refers to all persons apart from duly authorised staff and patients and may include, but is not limited to, students, visiting medical staff from private health facilities, media personnel, medical company and commercial representatives and volunteers.

There are two separate aspects to consent in this context:

1. consent to the visitor receiving the patient's confidential information; and
2. the fact that the visitor will be in attendance during the procedure may be considered a factor relevant to the patient's decision to provide their consent to the procedure.

There are a number of exceptions to the prohibition on disclosure of confidential information in the *Hospital and Health Boards Act 2011* (Qld) (HHB Act) that may permit a patient's confidential information to be disclosed to visitors in the operating theatre during a patient's procedure. For further information refer to Part 7 of the HHB Act (https://www.legislation.qld.gov.au/view/html/inforce/current/act-2011-032). **However it is best practice to obtain a patient's consent to disclosure of their confidential information, wherever possible.**

It is likely that the presence of a particular visitor in the operating theatre will be of greater importance to some patients than others in the context of providing patient consent. A patient's view on the presence of a visitor may depend on a range of factors including their personal circumstances, temperament, attitude, and level of understanding, cultural and ethnic background and the nature of the procedure. Consequently, it is not possible to provide an all-encompassing answer as to whether a patient needs to provide consent to a visitor being present as it will depend on the circumstances of each case. **It would generally be best practice to seek a patient's consent to a visitor being present in the operating theatre in each instance. Such consent may be obtained verbally and documented by the relevant health practitioner in the patient's medical record.**

1.13 What are the organisational responsibilities of the health care facility?

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

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 and invasive medical imaging examinations, as outlined in *Section 1.5: When should consent be obtained in writing?*, it is the responsibility of the health care 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[32].

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[33], health practitioners notify the relevant Health Service Administrator of all incidents, as soon as practicable, where health care has been provided without valid informed consent. This excludes limited circumstances such as emergency health care to adult patients who do not have capacity (see *Section 2.3: Situations where consent may not be needed to provide health care to an adult who lacks capacity*) and urgent and life-saving health care to children and young persons (see *Section 3.2: Informed decision-making for urgent and life-saving health care to children and young persons*). Consent breaches are to be lodged in Queensland Health Clinical Incident Management System and the incident must be managed according to the Department of Health, Health Service Directive Guideline https://www.health.qld.gov.au/system-governance/policies-standards/health-service-directives/patient-safety/clinical-incident-management

Also, as a component of the clinical risk management program, the health care facility should undertake, as a minimum, an annual audit to measure compliance with the HHS specific informed decision-making process and the implementation standard (Refer to your HHS HR Unit for more information).

Part 2 Informed decision-making and consent for adults who lack or have impaired capacity to make decisions[34]

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 health care, 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.

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[32] *Consent to Treatment Policy*, 2016, Department of Health Western Australia https://healthywa.wa.gov.au/~/media/Files/Corporate/Policy%20Frameworks/Clinical%20Governance%20Safety%20and%20Quality/Policy/WA%20Health%20Consent%20to%20Treatment%20Policy/Supporting/WA-Health-Consent-to-Treatment-Policy.pdf

[33] At the time of publication, these are Indemnity for Queensland Health Medical Practitioners Human Resources Policy I2 (2020) and Indemnity for Queensland Health Employees and Other Persons Human Resources Policy I3 (2009) replaced by Queensland Government Indemnity Guideline https://www.health.qld.gov.au/__data/assets/pdf_file/0023/164093/qh-pol-153.pdf and https://www.forgov.qld.gov.au/__data/assets/pdf_file/0030/187185/legal-protection-indemnity-guideline.pdf

[34] This section is based on the *Guardianship and Administration Act 2000* (Qld) (effective as at 30 November 2020)

Refer to *Section 1.7.1: Supported decision-making* and to the 2016 report: *Decision-making support and Queensland's guardianship system*, released by the Office of the Public Advocate for further information. http://www.justice.qld.gov.au/__data/assets/pdf_file/0010/470458/OPA_DMS_Systemic-Advocacy-Report_FINAL.pdf

2.1 When consent isn't required for an adult who has impaired capacity to consent

A careful assessment of the adult's capacity should be undertaken to confirm the patient does not have capacity to consent to health care at a specific time as described in *Section 1.7: Is this adult patient able to make a decision about health care themselves?* In most circumstances where patients lack capacity to make a decision about health care themselves, it is necessary to obtain consent from a substitute decision-maker before providing health care. However, for adults who have impaired capacity, consent may not be required to administer health care (but **not '**special health care') in specific circumstances pursuant to section 62 to section 64 of the *Guardianship and Administration Act 2000.*

'Special health care' for an adult means:

- removal of tissue from the adult while alive for donation to someone else
- sterilisation of the adult
- termination of a pregnancy of the adult
- participation by the adult in special medical research or experimental health care
- electroconvulsive therapy or a non-ablative neurosurgical procedure for the adult
- health care that has been prescribed under the *Guardianship and Administration Act 2000* as special health care of the adult.

There are additional considerations relevant to capacity to consent to treatment for a mental illness as outlined in the *Mental Health Act 2016* (Qld). See *Section 4.2 Considerations for persons receiving treatment and care under the Mental Health Act 2016.*

2.1.1 Urgent health care for an adult:

Refer to section 63 of the *Guardianship and Administration Act 2000*.

Health care, other than special heath care of an adult, may be carried out without consent if the adult's health provider reasonably considers the adult has impaired capacity for the health matter concerned and either the:

- health care should be carried out urgently to meet imminent risk to the adult's life or health; or
- the health care should be carried out urgently to prevent significant pain or distress to the adult and it is not reasonably practicable to get consent from a person who may give it under the *Guardianship and Administration Act 2000* or the *Powers of Attorney Act 1998*.

It is important to note this includes providing life-sustaining measures.

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 operation[35]. This includes:

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

A blood transfusion is not a life-sustaining measure.

However, health care provided to urgently meet imminent risk to the adult's life or health may not be carried out without consent if the health provider knows the adult **objects** to the health care in an Advance Health Directive. Health care provided to prevent significant pain or distress to the adult may not be carried out without consent if the health provider knows the adult **objects** to the health care, unless:

[35] *Guardianship and Administration Act 2000* (Qld) Schedule 2, s5A

- the adult has minimal or no understanding of one or both of the following—
  (i) what the health care involves;
  (ii) why the health care is required; and
- the health care is likely to cause the adult—
  (i) no distress; or
  (ii) temporary distress is outweighed by the benefit to the adult, of the health care.

The health provider must certify in the adult's clinical records as to the various things enabling the health care to be carried out pursuant to section 63 of the *Guardianship and Administration Act 2000*.

For the purposes of urgent health care provided under section 63 of the *Guardianship and Administration Act 2000*, health care of an adult does not include withholding or withdrawal of a life-sustaining measure for the adult.

2.1.2 Health care without significant risk for adult patients who lack capacity to consent

Where patients lack capacity to make their own health care decisions, 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)[36] without consent if it is otherwise in the patient's best interests.

2.1.3 Life sustaining measures in emergencies:

Refer to section 63A of the *Guardianship and Administration Act 2000*.

A life-sustaining measure may be withheld or withdrawn for an adult without consent if the adult's health provider reasonably considers -

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

However, the measure may not be withheld or withdrawn without consent if the health provider knows the adult **objects** to the withholding or withdrawal.

The health provider must certify in the adult's clinical records as to the various things enabling the measure to be withheld or withdrawn because of section 63A of the *Guardianship and Administration Act 2000*. For this purpose, artificial nutrition and hydration is not a life-sustaining measure.

2.1.4 Minor, uncontroversial health care:

Refer to section 64 of the *Guardianship and Administration Act 2000*.

Health care, other than special health care, of an adult may be carried out without consent if the adult's health provider:

- reasonably considers the adult has impaired capacity for the health matter concerned;
- reasonably considers the health care is necessary to promote the adult's health and wellbeing, is of the type that will best promote the adult's health and wellbeing and is minor and uncontroversial and
- and does not know, and cannot reasonably be expected to know, of:

[36] *Guardianship and Administration Act 2000,* Schedule 2, s5 - *explicitly* defines these as not being health care.

- a decision about the health care made by a person who is able to make the decision under the *Guardianship and Administration Act 2000* or the *Powers of Attorney Act 1998* *or*
- any dispute among persons the health provider reasonably considers have a sufficient and continuing interest in the adult about the carrying out of the health care or the capacity of the adult for the health matter.

Examples of minor and uncontroversial health care mentioned directly above include the administration of an antibiotic requiring a prescription and the administration of a tetanus injection.

However, the minor and uncontroversial health care may not be carried out without consent if the health provider knows, or could reasonably be expected to know, the adult **objects** to the health care.

The health provider must certify in the adult's clinical records as to the various things enabling the health care to be carried out because of section 64 of the *Guardianship and Administration Act 2000*.

2.1.5 Objection:

Refer to the *Guardianship and Administration Act 2000* for further information.

For the purposes of the sections on urgent health care, life sustaining measures in emergencies and minor, uncontroversial health care, the term 'object' is defined in the *Guardianship and Administration Act 2000*. In the context of an objection by an adult to health care, object means:

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

An indication may be given in an enduring power of attorney or Advance Health Directive or in another way, for example, orally or by conduct.

2.2 Who can consent for adult patients who lack or have impaired capacity?: Substitute decision makers.

If an adult patient lacks capacity to make a decision about health care, 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 (see *Section 2.2.1: What are Advance Health Directives and when do they apply?*). If the adult has made an Advance Health Directive giving a direction about the matter, the matter may only be dealt with under the direction.

If there is no valid Advance Health Directive, a decision should be sought from a substitute decision-maker in the following order of priority[37]

- if the adult has not made an Advance Health Directive and the Queensland Civil and Administration Tribunal has appointed one or more guardians for the matter or made an order about the matter, the matter may only be dealt with by the guardian or guardians or under the order
- if there is no Advance Health Directive, no guardian, or order and the adult has made one or more enduring documents (for example, an enduring power of attorney) appointing one or more attorneys for the matter, the matter may only be dealt with by the attorney or attorneys for the matter appointed by the most recent enduring document
- if none of the above applies, the matter may only be dealt with by the statutory health attorney.

The dot points above do not apply to a health matter relating to health care that may be carried out without consent above at *Section 2.1: When consent isn't required for an adult who has impaired capacity to consent*.

[37] *Guardianship and Administration Act 2000* (Qld) s66

A statutory health attorney can make any decision about the health matter that the adult could lawfully make if the adult had capacity for the matter. A statutory health attorney can only exercise their power during any or every period the adult has impaired capacity for the matter.

For a health matter, an adult's statutory health attorney is the first, in listed order, of the following people who is readily available and culturally appropriate to exercise power for the matter:

- a spouse of the adult, if the relationship between the adult and the spouse is close and continuing;
- a person who is 18 years or more who has the care of the adult and is not a paid carer for the adult;
- a person who is 18 years or more who is a close friend or relation of the adult and is not a paid carer for the adult.

Without limiting who is a person who has the care of the adult, a person has the care of an adult if the person:

- provides domestic services and support to the adult; or
- arranges for the adult to be provided with domestic services and support.

If an adult resides in an institution (for example, a hospital, nursing home, group home, boarding-house or hostel) at which the adult is cared for by another person, the adult is not, merely because of this fact, to be regarded as being in the care of the other person; and remains in the care of the person in whose care the adult was, immediately before residing in the institution.

If there is a disagreement about which of two or more eligible people should be the statutory health attorney or how the power should be exercised, see the *Guardianship and Administration Act 2000*, section 42 (Disagreement about health matter).

If no-one above is readily available and culturally appropriate to exercise power for a matter, the Public Guardian is the adult's statutory health attorney for the matter.

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

For further detailed discussion about Advance Health Care Directives, the Queensland Health End of Life Care: Decision Making for Withholding and Withdrawing Life-Sustaining Measures from Adult patients, Implementation guidelines Part 1 and Part 2 https://www.health.qld.gov.au/__data/assets/pdf_file/0037/688618/acp-guidelines.pdf and https://clinicalexcellence.qld.gov.au/sites/default/files/docs/clinical-pathways/care-plan-dying-person/care-plan-dying-person-health-professional.pdf
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.[38]

An Advance Health Directive can be used to provide consent to health care or the withholding of health care. Where the decision in the Advance Health Directive relates to life-sustaining measures, certain conditions must 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 takes precedence over health care requests made by family members or substitute decision-makers. However, an Advance Health Directive is not applicable where the patient has or regains capacity and can make their own decisions.

Advance Health Directives do not expire but may be revoked at any time, as long as the patient has the capacity to do so. It is recommended the document be reviewed by the principal every two years or if the principal's health changes significantly[39]. Further information can be obtained from the Office of the Public Guardian: adult@publicguardian.qld.gov.au and https://www.publications.qld.gov.au/dataset/power-of-attorney-and-advance-health-directive-forms

[38] *Powers of Attorney Act 1998* (Qld) s35 to s40.

2.2.2 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 (the standard document is Form 4, available at; https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/56b091a2-4c65-48a0-99e1-01661c4d9e77/form-4-advance-health-directive-queensland.pdf?ETag=2d1d93c9b87bdc6db996ddb5107cdc71 and
2. signed by the adult patient (or by an eligible signer[40] on the adult's behalf); and
3. signed and dated by an eligible witness[41] and certified that the document was signed in the presence of the eligible witness 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. The *Powers of Attorney Act 1998* provides certification must be by one of the following persons: the patient who made the Advance Health Directive, a justice of the peace, a commissioner for declarations, a notary public, a lawyer, a trustee company under the *Trustee Companies Act 1968* or a stockbroker. 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, the patient/principal can revoke previous directions in the Advance Health Directive or the whole document.

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
- if the requested health care in the Advance Health Directive is unlawful.

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 (see *Section 2.2: Who can consent for adult patients who have impaired capacity?:Substitute decision makers).*

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[39] *'Changing or revoking an advance health directive'* https://www.publications.qld.gov.au/dataset/power-of-attorney-and-advance-health-directive-forms/resource/e904421c-b1e7-4f43-a918-474ae8c496fa

[40] For definition of 'eligible signer' see *Powers of Attorney Act 1998* (Qld) s30.

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

If it is established that the Advance Health Directive is valid, the directions must be followed[42]. It is a legally binding document.

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, if made by the principal after the date of the Advance Health Directive, 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 health practitioner 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.

To keep a record of the version of the Advance Health Directive as evidence that the document was sighted and relied upon in a particular situation, 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.

2.2.3 Deciding not to follow an Advance Health Directive

If, after careful consideration, a medical officer chooses not to follow a patient's Advance Health Directive[43], 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 Directive[44], 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
- a health provider has reasonable grounds to believe that a direction in an Advance Health Directive is uncertain or inconsistent with good medical practice or that circumstances, including advances in medical science, have changed to the extent that the terms of the direction are inappropriate.

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[42] 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 2.2.3 'Deciding not to follow an Advance Health Directive'* of the quoted text for more detail.

[43] This would include where the document is an original document, a photocopy or facsimile copy.

[44] The *Powers of Attorney Act 1998,* at s103 offers statutory protection to health providers where they have not acted in accordance with an Advance Health Directive in certain circumstances.

The health practitioner must consult with any attorney appointed under the Advance Health Directive, if the health practitioner seeks to provide health care not in accordance with the directions in the Advance Health Directive[45] because he or she believes the directive is uncertain.

However, the onus of proof of uncertainty would lie with the medical officer who may be required to defend the decision not to follow the Advanced Health Directive in a court of law. Therefore, the need to clearly document the reasoning behind the decision cannot be overstated.

If there is any doubt about whether an Advance Health Directive is valid, legal advice should 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 preserve life or limb function, keep meticulous clinical records and be prepared to justify their decision.

2.2.4 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 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 decision[46(a)]. 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 made 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.

2.2.5 Advance Health Directives and the Mental Health Act 2016

The *Mental Health Act 2016* (Qld)[46(b)] requires clinicians to consider whether there is a less restrictive way available to obtain consent for a person's treatment, other than providing involuntary treatment under a Treatment Authority. A less restrictive way includes consent provided in an Advance Health Directive (if made by the person when they have capacity), or with the consent of an attorney or guardian, if the person's treatment needs can be met in that way. Section 225(1) of the *Mental Health Act 2016* requires that the Chief Psychiatrist must establish and maintain a system for keeping electronic records of:

- advance health directives
- enduring powers of attorney for a personal matter; and
- appointments of nominated support persons.

Further information on Advance Health Directives and the *Mental Health Act 2016* is available at www.health.qld.gov.au/mental-health-act.

[45] *Powers of Attorney Act 1998* (Qld), s103.

[46] (a) 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.] https://eprints.qut.edu.au/19152/

[46] (b) *Mental Health Act 2016* (Qld)

2.2.6 Use of restrictive practices when providing health care to adult patients who lack or have impaired capacity and cannot provide consent

Queensland Health staff consulting this Guide must be mindful that there is no single overarching restrictive practices legislation in Queensland. Your obligations and responsibilities in relation to restrictive practices may vary depending on the setting or type of health care being provided. This section of the Guide is general in nature and does not intend to cover all the restrictive practices legislative obligations. For example, there are varying definitions and specific requirements regarding the use of restrictive practices under the *Mental Health Act 2016*, *Aged Care Act 1997* and *Disability Services Act 2006* which apply in specific circumstances.

The use of restrictive practices must always be authorised or justified by law.

Use of restrictive practices in Queensland Health Hospital and Health Services generally

Queensland Health is committed to minimising and, where possible, eliminating the use of restrictive practices in Queensland Health Hospital and Health Services (HHSs). Restrictive practices are practices or interventions that have the effect of restricting the rights or freedom of movement of a person and are primarily used with the intention of protecting that person or others from harm.

There are situations in which the use of restrictive practices may be necessary to protect a patient or others from harm. A restrictive practice should only be implemented:

- in a manner consistent with the relevant legislative obligations applying to the type of health care or setting in which it is provided; and
- only after having obtained consent; or
- in exceptional circumstances where there is an imminent risk to the life or health of the patient or others and there are no other less restrictive means available.

Broadly, Queensland Health expects HHSs and staff to meet their relevant legislative obligations, applicable to the setting or type of health care being provided. This expectation also includes applying the following general principles in relation to the use of restrictive practices:

- as a last resort to prevent harm to a patient or others and after having considered how the restrictive practice may impact the patient
- after having considered other alternatives to minimise harm to the patient and others, or to optimise patient outcomes, and these alternatives are either inappropriate or ineffective
- in the least restrictive form and for the shortest time needed
- when the potential benefits, whether to the patient or protection of others from harm, clearly outweigh any distress (even temporary) that might be caused to the patient
- in accordance with the relevant legislative requirements (depending on the applicable setting), including under the:
    - *Powers of Attorney Act 1998* (Qld)
    - *Guardianship and Administration Act 2000* (Qld)
    - *Criminal Code Act 1899* (Qld)
    - *Human Rights Act 2019* (Qld)
    - *Mental Health Act 2016* (Qld)
    - *Disability Services Act 2006* (Qld)
    - *Aged Care Act 1997* (Cth) and *Quality of Care Principles 2014* (Cth)
    - *National Disability Insurance Scheme (NDIS) Act 2013* (Cth) and *NDIS (Restrictive Practices and Behaviour Support) Rules 2018* (Cth)
    - any other relevant law
- in accordance with relevant local Hospital and Health Service, state and national standards, guidelines, and policies.

Use of restrictive practices for patients 18 years of age and older

For patients aged 18 years and over who do not have capacity to consent or who decline to provide consent, *(and who are not receiving treatment and care for a mental illness under the Mental Health Act 2016)*, the use of restrictive practices may be authorised under the *Guardianship and Administration Act 2000 (Qld)*. Namely, where:

- the relevant restrictive practice constitutes health care,[47] that is, where the practice is care or 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
    - 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* or the *Powers of Attorney Act 1998*
- other requirements of the *Guardianship and Administration Act 2000* relating to providing health care to a person who lacks capacity, are satisfied. This effectively means that either the requirements of s.63 of the *Guardianship and Administration Act 2000* in relation to 'urgent health care' outlined in the point above are met, *or* the consent of a relevant substitute decision-maker is obtained.

Restrictive practices under the *Guardianship and Administration Act 2000*

A health provider[48] and a person acting under the health provider's direction or supervision may use the minimum force necessary and reasonable to carry out health care authorised under the *Guardianship and Administration Act 2000.*[49]

Therefore, except in an acute emergency, before using a restrictive practice, the health practitioner must ensure 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 restrictive practices 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.

Chapter 5B of the *Guardianship and Administration Act 2000* sets out additional rules which only apply to adults with an intellectual or cognitive disability who receive disability services from a relevant service provider. In particular, Chapter 5B contains rules concerning the requirements for giving consent for restrictive practice matters. For further information, refer to the section on '*Restrictive practices under the Disability Services Act 2006'* below.

Restrictive practices under the *Mental Health Act 2016*[50]

For patients receiving treatment and care for a mental illness in an authorised mental health service, the use of restrictive practices must only occur as a last resort to prevent imminent and serious risk of harm to patients and staff, where less restrictive interventions have been unsuccessful or are not feasible. They must be used in accordance with the requirements of the *Mental Health Act 2016*[50] and relevant Chief Psychiatrist Policies.

Under the *Mental Health Act 2016*[50]*,* a person must not administer medication to a patient unless the medication is clinically necessary for the patient's treatment and care for a medical condition. Treatment and care of a

[47] *Guardianship and Administration Act 2000* (Qld), schedule 2, s5 - definition of health care: the care or treatment of, or a service or a procedure for, the adult (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

[48] *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

[49] *Guardianship and Administration Act 2000* (Qld) s75

[50] *Mental Health Act 2016* (Qld)

medical condition includes preventing imminent serious harm to the patient or others.

For further information, refer to *Section 4.2 Considerations for persons receiving treatment and care under the Mental Health Act 2016* and https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/policies-guidelines

Restrictive practices under the *Disability Services Act 2006*

The *Disability Services Act 2006* sets out rules in relation to the use of restrictive practices for 'service providers' who provide disability services or supports to adults with an intellectual or cognitive disability. Relevantly, it sets out rules in relation to:

- concepts for using restrictive practices (e.g., assessment of adults and the principles guiding the use of restrictive practices for those with an intellectual or cognitive disability);
- the requirements for implementing relevant restrictive practices under the *Disability Services Act 2006*; and
- obtaining consent for the use of restrictive practices.

Service providers who receive NDIS funding to deliver services to NDIS participants must also meet the requirements and obligations for restrictive practices under the *National Disability Insurance Scheme Act 2013 (NDIS Act)* and *NDIS (Restrictive Practices and Behaviour Support) Rules 2018* as outlined below.

For further information, refer to:

- Positive Behaviour Support and Restrictive Practices - Department of Child Safety, Seniors and Disability Services
- Understanding behaviour support and restrictive practices- NDIS Quality and Safeguards Commission
- Department of Health Queensland, Disability Service Plan 2022-2024.

Restrictive practices under the *Aged Care Act 1997* and *Quality of Care Principles 2014*

The *Aged Care Act 1997* and *Quality of Care Principles 2014* set out detailed requirements in relation to the use of restrictive practices in residential aged care, including in relation to:

- the different types of restrictive practices in residential aged care and their use;
- emergency use of restrictive practices;
- documentation and reporting requirements;
- monitoring, review and assessment requirements; and
- obtaining informed consent for the use of a restrictive practice.

Under the *Quality of Care Principles 2014* informed consent for the use of a restrictive practice must be obtained from the consumer, unless the use of the restrictive practice is necessary in an emergency (i.e., a serious or dangerous situation that is unanticipated or unforeseen and that requires immediate action). If the consumer does not have the capacity to give that consent, it must be obtained from their restrictive practice substitute decision-maker. QH must ensure that consent has been obtained in a manner consistent with relevant Queensland legislative requirements and that the consent is recorded.

QH residential aged care providers delivering services to NDIS participants in their facilities must meet the requirements and obligations for restrictive practices under the *National Disability Insurance Scheme Act 2013 (NDIS Act)* and *NDIS (Restrictive Practices and Behaviour Support) Rules 2018* as outlined below.

For further information, refer to

- Restrictive practices provider resources- Aged Care Quality and Safety Commission
- Restrictive practices in aged care; a last resort- Australian Government Department of Health and Aged Care.

Restrictive practices under the *National Disability Insurance Scheme Act 2013 (NDIS Act)* [51] and *NDIS (Restrictive Practices and Behaviour Support) Rules 2018* [52]

The *NDIS Act 2013* and *NDIS (Restrictive Practices and Behaviour Support) Rules 2018* outline the requirements and obligations for services receiving NDIS funding, including those relating to consent to use any regulated restrictive practice with NDIS participants. The *NDIS Act 2013 and the NDIS Rules 2018* also apply to residential aged care providers who are registered NDIS providers delivering residential aged care services to a resident who is a NDIS participant *(note, this is applicable only for residents who are NDIS participant/s, not for all residents).*

Staff should consult their local policies in relation to the use of restrictive practices in the NDIS setting. This guide is not intended to cover the relevant NDIS legislation and requirements in detail or be a substitute for any local policies.

Additionally, for further information regarding the requirements for services in relation to restrictive practices in the NDIS setting, refer to:

- https://www.ndiscommission.gov.au/providers/understanding-behaviour-support-and-restrictive-practices-providers
- https://www.ndiscommission.gov.au/sites/default/files/2022-02/regulated-restrictive-practice-guide-rrp-20200_0.pdf
- https://www.ndiscommission.gov.au/providers/registered-ndis-providers/provider-obligations-and-requirements/ndis-practice-standards
- https://www.ndiscommission.gov.au/about/ndis-code-conduct.

Application of NDIS in residential aged care (RAC)

There are significant differences between the behaviour support requirements in aged care and in the NDIS. RAC providers are required to meet the obligations and requirements of the *NDIS Act 2013* and the *NDIS Rules 2018* for the use of any restrictive practice for residential aged care residents who are NDIS participants.

Note, the NDIS legislative requirements apply specifically to residents who are NDIS participant/s, they do not apply to residents who are not NDIS participants.

Staff working in a residential aged care service must satisfy themselves on a case by case basis of the requirements in relation to the use of restrictive practices prior to implementation, e.g. whether the Restrictive Practices and Behaviour Support Rules 2018 apply to a particular resident who is also an NDIS participant.

For further information for RAC providers, refer to:

- https://www.ndiscommission.gov.au/providers/registered-ndis-providers/provider-obligations-and-requirements/residential-aged-care#paragraph-id-2318
- https://www.ndiscommission.gov.au/providers/registered-ndis-providers/provider-obligations-and-requirements/residential-aged-care-0
- https://www.ndiscommission.gov.au/providers/complaints-and-incidents/incident-management-providers

2.2.7 'Special health care' that requires the consent of a Tribunal or Court for adult patients who have impaired capacity and cannot provide consent

There are certain types of 'special health care' that require the consent of the Tribunal or Court to be given on behalf of an adult who lack the capacity to provide consent, being:[53]

- 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

[51] https://www.legislation.gov.au/Details/C2022C00206

[52] https://www.legislation.gov.au/Details/F2020C01087

[53] *Guardianship and Administration Act 2000* (Qld) s68 to s74

- participation by an adult in special medical research or experimental health care
- special health care of an adult that may be restricted under future legislation.

2.3 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 health care 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 health care 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 health care by the patient, for example through an Advance Health Directive. See *Section 2.2.1: What are Advance Health Directives and when do they apply?* and *Section 2.2.2: Consent under an Advance Life Directive*, for further information.

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.[54]

However, artificial nutrition and hydration may not be withheld or withdrawn in acute circumstances[55] such as a stroke or myocardial infarction.

The medical practitioner must have 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 recommendation is not to provide health care.

By law[56], 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.

In a situation where an Advance Health Directive exists which indicates a patient’s wishes to withhold or withdraw a life-sustaining measure and the patient lacks capacity, the Advance Health Directive cannot operate unless:

- one of the following applies:
    - 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 (that is, two medical practitioners in total), the patient may reasonably be expected to die within one year

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[54] *Guardianship and Administration Act 2000* (Qld) s63A

[55] *Guardianship and Administration Act 2000* (Qld) *s63A(4)*

[56] *Guardianship and Administration Act 2000* (Qld) s66B

- the patient 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, heartbeat or breathing)
- the patient 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)
- the patient 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

- for a direction to withhold or withdraw artificial nutrition or artificial hydration – the commencement or continuation of the measure would be inconsistent with good medical practice and
- the patient has no reasonable prospect of regaining capacity to make decisions about health care.[57] See *Section 2.2.1: What are Advance Health Directives and when do they apply?* and *Section 2.2.2: Consent under an Advance Life Directive for further information*.

2.3.2 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 must be obtained to withhold or withdraw artificial hydration and/or nutrition.

In 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 certain criteria exist (See *Section 2.2.1: What are Advance Health Directives and when do they apply?* and *Section 2.2.2: Consent under an Advance Life Directive*, for further information).

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 *End of Life Care: Decision Making for Withholding and Withdrawing Life-Sustaining Measures from Adult patients, Implementation guideline Part 1: and Part 2.*

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

There are some procedures which are prohibited by law, for example:

- female genital mutilation[58]
- non-regenerative tissue removal from a living child for donation purposes.[59]

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

- termination of pregnancy[60]
- regenerative tissue removal from a living child for donation purposes[61]

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[57] *Powers of Attorney Act 1998* (Qld) s36
[58] *Criminal Code Act 1899* s 323A
[59] *Transplantation and Anatomy Act 1979* s18
[60] *Criminal Code Act 1899* s224 to s226
[61] *Transplantation and Anatomy Act 1979* s12B

- removal of blood from a child for transfusion or therapeutic purpose[62]
- sterilisation of a child with impairment[63]

These issues are not dealt with further in this Guide and the reader is referred to the legislation which has been listed in the footnotes.

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 words 'children' or 'young person' are 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 health care are often 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 responsibility[64] except in specific situations. Persons with parental responsibility have a responsibility to consent to health care 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 health care 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 Kingdom[65] (see *Section 3.1.5: How to assess whether a child or young person is Gillick competent and has capacity to consent to health care*).

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 health care, 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 has the ability to provide consent to health care.

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 possible adverse effects) so they might support the young person in their decision and during the health care
- 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 health care (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.

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[62] *Transplantation and Anatomy Act 1979* s18

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

[64] *Family Law Act 1975 (Cth)*, Part VII, Division 2, s61A to s61F

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

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.
The law requires that child protection concerns are reported. A doctor or registered nurse must make a report to the Department of Communities, Child Safety and Disability Services if they form a reasonable suspicion that a child has suffered, is suffering or is at unacceptable risk of suffering significant harm caused by physical or sexual abuse and may not have a parent able and willing to protect that child from harm. They must also notify the HHS Child Protection Liaison or Child Protection Advisor[66]. Visit the Department of Communities, Child Safety and Disability Services website for additional information: https://www.dcssds.qld.gov.au/our-work/child-safety

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 health care, they are able to do so. The terms 'Gillick competent' and 'mature minors' are sometimes used to describe this group of patients (see *Section 3.1.1: At what age can children and young persons consent for themselves?).*

Parents[67]

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 health practitioner before separated or divorced parents need to consent to their child receiving health care.

Adoptive or surrogacy[68] 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 relative[69].

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

With respect to Aboriginal and Torres Strait Islander peoples who are in the traditional role of a parent refer to section 61F of the *Family Law Act 1975,* which provides guidance on the meaning of parent for both Aboriginal and Torres Strait Islander peoples.

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 and Disability Services 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 health care carries significant risk, and/or the parent objects to the health care 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 health care to children and young persons* and can provide health care without consent where it is urgent or life-saving and in the best interests of the child or young person.

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[66] *Child Protection Act, 1999*, Section 13E

[67] *Family Law Act 1975* Part VII, Division2, s61A to s61F

[68] *Surrogacy Act 2010* Chapter 1, Part 3, s7

[69] *Adoption Act 2009* refer to the meaning of a parent in the relevant section of this Act.

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* [70] or *Adoption Act 2009* [71] has the same rights and responsibilities as a parent in relation to consent.

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 health care on behalf of a child or young person.

The Supreme Court of Queensland or the Family Court

(also refer to *Section 3.4: When is consent from a parent, guardian or child/young person not enough?)*

The Supreme Court of Queensland can exercise its role as the supreme parent of children[72]. The Family Court of Australia has a similar authority[73].

An application to the court should be considered in situations, and with procedures, that are so serious that neither young person, parent nor a 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 young persons with impaired capacity, 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 health care 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 health care 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 Director or Medical Superintendent will have the contact details of the HHS 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 health care[74]. 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 Department of Child Safety, Seniors and Disability Services or a suitable person, including a member of the child's extended family[75]. Sometimes, parents retain guardianship of the child while the Chief Executive or another suitable person is granted custody.

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[70] *Child Protection Act 1999* (Qld) s13

[71] *Adoption Act 2009* (Qld) s13

[72] Parens patriae jurisdiction

[73] *Family Law Act 1975* (Cth) 1975 s67ZC (1)

[74] *Child Protection Act* 1999 (Qld) s13

[75] *Family Law Act 1975* (Cth) s61F

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 health care matters but may not include decisions about future long-term health care.

Children placed in out-of-home care may be in the care of formally approved foster carers or kinship carers[76]. The nature of the care arrangements under which the child is placed usually determines what authority these carers have to make health care decisions, however, these carers are generally only granted custody rights for the child.

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 health care. It would be advisable to liaise with the Department of Child Safety, Seniors and Disability Services regarding the legal status of children and the nature of care arrangements (that is, who has responsibility for daily health care and long-term health care decisions) (see *Section 3.1.4: What evidence of the authority to consent to health care 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 health care 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, Department of Child Safety, Seniors and Disability Services 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 Child Safety, Seniors and Disability Services, has published the Child Safety Practice Manual: https://cspm.csyw.qld.gov.au/ which provides guidance on decision-making about health care for children in care[77]. 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 health care 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 health care would be viewed as daily care or not, and, in such cases, staff are encouraged to obtain advice from the Department of Child Safety, Seniors and Disability Services or seek legal assistance.

If the child or young person has the capacity to make a decision in respect of the proposed health care, 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 (see *Section 3.1.5: How to assess whether a child or young person is Gillick competent and has capacity to consent to health care*).

The Child Safety Practice Manual outlines the responsibilities a person with custody has in respect to a child's health care. These include the responsibility to seek health care 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 health care 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

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[76] *Child Protection Act 1999* (Qld) s82

[77] *Child Safety Practice Manual*, Department of Child Safety, Seniors and Disability Services https://cspm.csyw.qld.gov.au/

- contraception where one of the following applies:
  - a child is under 12 years of age
  - 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
- management of smoking behaviour.

Consent from a person with guardianship of the child 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 health care
- that the health care 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 health care (examination or treatment) is necessary to promote the child or young person's health and wellbeing
- that the health care (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 health care, they have done so.

3.1.4 What evidence of the authority to consent to health care 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 health care decisions for the child. This might include sighting a court order, certificate of approval as a foster carer or kinship carer[78] 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 Child Safety, Seniors and Disability Services 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.

[78] *Child Protection Act 1999* (Qld) s82(1) and s131

3.1.5 How to assess whether a child or young person is Gillick competent and has capacity to consent to health care

To establish that a child or young person has capacity to consent to health care, 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 health care, and the alternatives, including the consequences of not receiving the health care.

When assessing a child or young person's capacity, the following issues should be considered[79]:

- 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 health care, including the need for follow up or supervision after the health care
- the seriousness of the risks associated with the health care
- the consequences if the child or young person does not have the health care
- where the consequences of receiving the health care 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 health care or more serious the consequences, the stronger the evidence of the child or young person's capacity to consent to the specific health care 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 health care 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 health care that does not carry significant risk[80].

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 health care 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.

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

[80] *Consent for Treatment and Confidentiality in Young People*, September 2004, the former Medical Practitioners Board of Victoria pp1 to 6.

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

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

In this situation a medical practitioner may:

- explore carefully the reasons for the child or young person 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 health care 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 health care, 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 health care

Both parents and older children or young persons may hold concurrent ability to consent to the child or young person's health care. In most cases, this will not cause a problem, but disagreement sometimes arises between the child or young person, and their parent or guardian about what health care 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 health care 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.[81]

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 health care.

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

[81] Peter J.M. MacFarlane and Simon J Reid, *2006 Queensland Health Law Handbook 16th Edition,* Queensland Department of Health pp81 to 83

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

In situations where parents or guardians have given advance consent to a specific form of health care 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:

- confirming the child's identity
- confirming the site and side of the procedure
- giving consent to additional health care or a changed health care plan
- reassuring and supporting the child
- providing supervision after the health care.

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 health care would be postponed until the validity of the informed consent has been confirmed.

For more discussion see *Section 4.7: Childhood and school-based programs (including oral health and immunisation programs*).

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

3.2.1 General approach to consent for urgent and life-saving health care 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) or from someone with parental decision-making responsibility. However, if this is not possible, health care 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 health care must be:

- 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 health care 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 health care 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 health care 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 [82] 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.

[82] *Criminal Code Act 1899* (Qld) s282.

3.2.2 Blood and blood product transfusions in children and young persons

Usually consent is required before providing 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 (see *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 *Transplantation and Anatomy Act 1979* [83] 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) document 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 *Transplantation and Anatomy Act 1979* is silent with regards to those situations where a child may be Gillick competent and may have capacity to make decisions about his/her health care 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.

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.

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[83] *Transplantation and Anatomy Act 1979* (Qld) s20.

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 order[84].

Consent by the child or young person to the examination should be sought 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 cases[85].

Examples of treatments where only court authorisation of the health care 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 www.qlrc.qld.gov.au/ and
- Queensland Family and Child Commission www.qfcc.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 health care of a child or young person.

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[84] *Child Protection Act 1999* (Qld) s97.

[85] *Consent to Health Care of Young People - Volume One - The Law and Need for reform* (1996) pp158 to164, Queensland Law Reform Commission.

Part 4 Informed decision-making and consent in specific health care 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. It is suggested that the chaperone offered be a clinical member of staff rather than a family member or friend, and that if the patient requests, a support person also be provided.

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/health care options so they can make an informed decision.

If a patient declines to have another health practitioner present during the examination, this should be documented including the actions taken. Similarly if a patient consents to the examination but declines a chaperone, this should also be documented. A staff member should remain within hearing outside the door/screen of the examination area (as protection for the examining health practitioner).

Where practice standards require written consent (for example, the Diagnostic Imaging Accreditation Scheme (DIAS) Practice Accreditation Standards January 2016 – Transvaginal Ultrasound it should be noted that Queensland Health is supportive of such standards and recommends as best practice that written consent be obtained. Visit: https://www.safetyandquality.gov.au/standards/diagnostic-imaging/diagnostic-imaging-accreditation-scheme-standards Also refer to *Section 1.5: When should consent be obtained in writing?*

In other cases 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 Considerations for persons receiving treatment and care under the *Mental Health Act 2016*

The *Mental Health Act 2016* authorises the involuntary treatment and care of individuals with a mental illness who do not have **capacity to consent** to be treated and where there is no other **less restrictive way**.[86]

Capacity for people with a mental illness
A person is presumed to have capacity to make decisions about their treatment and care and other matters under the *Mental Health Act 2016*. The presumption that a person has capacity can be rebutted where it can be shown that the person lacks capacity to consent to treatment at the time the treatment decision needs to be made. Capacity under section 14 of the *Mental Health Act 2016* is defined differently than under other statutory regimes within Queensland. A person has capacity to consent to be treated for their mental illness if:

- The person is capable of understanding in general terms:
  - That the person has a mental illness, or symptoms of an illness, that affects mental health and wellbeing, and
  - The nature and purpose of the treatment for the illness, and
  - The benefits and risks of the treatment and alternatives, and
  - The consequences of not receiving treatment, and
- Is capable of making a decision and communicating it in some way.

Accordingly, if it is demonstrated that a person does not meet one of the above factors, the presumption of capacity will be rebutted (i.e., the person will not have capacity for the purposes of the *Mental Health Act 2016*).

Less Restrictive Way
The *Mental Health Act 2016* requires clinicians to consider whether there is a less restrictive way for a person to receive treatment, other than providing involuntary treatment under a Treatment Authority under the *Mental Health Act 2016*. A less restrictive way for a person to receive treatment includes consent provided in an Advance Health Directive (if made by the person when they have capacity), or consent of an attorney or guardian, if the person's treatment needs can be met in that way.

For more information refer to Treatment and care under the Mental Health Act 2016 | Queensland Health.

4.2.1 Can regulated mental health treatments be given without consent?

Electroconvulsive therapy and non-ablative neurosurgical procedures are regulated treatments under the *Mental Health Act 2016.*[87] The *Mental Health Act 2016* sets out requirements for the approval and performance of these treatments to ensure appropriate safeguards are in place; these may only be performed by a doctor at a health facility declared by the Chief Psychiatrist to be an authorised mental health service for that purpose.

For further information regarding the use regulated treatment, please refer to the Chief Psychiatrist's policies and resources (https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/topics/treatment-care).

[86] *Mental Health Act 2016 (Qld)*
[87] *Mental Health Act 2016 (Qld) (Ch 7, Part 10)*

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 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 health care changes.

A Queensland Health Blood and Blood Products Transfusion Consent form (Blood and Blood Products Transfusion - Consent Form and Patient Information and Blood and Blood Products Transfusion - Patient Information 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 this requirement, an additional section within the procedure specific form, Blood and Blood Products Transfusion Consent is available. 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 condition, or a change in the treatment program (see *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 Clinical Excellence Commission[88] and the Australian Red Cross Blood Service[89] websites.

For children and young persons refer to *Section 3.2.2: Blood and blood product 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 health care 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 health care options available, the risks, and the effectiveness in their clinical situation. This might include:

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[88] Clinical Excellence Commission, New South Wales https://www.cec.health.nsw.gov.au/keep-patients-safe/blood-watch/information-for-consumers

[89] Australian Red Cross Blood Service https://www.lifeblood.com.au/patients/receiving-a-transfusion

- 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 health care, 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.

Where a medical practitioner reasonably considers an adult patient has an impaired capacity to make a decision about their health care, 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[90]. (see *Section 2.2.1: What are Advance Health Directives and when do they apply?* and *Section 2.2.2: Consent under an Advance Life Directive for further information*).

Patients of the Jehovah's Witness faith may carry a card containing information about their views about such health care, 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 health care. 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 have impaired capacity?* (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 product 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 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.[91]

The state-wide 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, subsequent changes in 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 (see *Section 2.1: When consent isn't required for an adult who has impaired capacity to consent;* and *Section 2.3: Situations where consent may not be needed to provide health care to an adult who lacks capacity*).

Note that *Section 4.1: Do patients need to give informed consent to intimate examinations?* applies during maternity care.

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[90] *Guardianship and Administration Act 2000* (Qld) s63.

[91] *National Midwifery Guidelines for Consultation and Referral: Care outside of Guidelines*, 3rd edition, 2013, Australian College of Midwives.

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

- 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[92].

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

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 state-wide written consent may be identified and the appropriate consent forms and documentation in the patient's clinical record will be 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
https://www.forgov.qld.gov.au/__data/assets/pdf_file/0019/203581/Health-Sector-Clinical-Records-Retention-and-Disposal-Schedule.pdf and
https://www.health.qld.gov.au/__data/assets/pdf_file/0026/397223/qh-imp-280-1.pdf

4.4.1 Termination of pregnancy

Current Queensland legislation[93] 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).

However please note that the recent Abortion Law Reform (Woman's Right to Choose) Amendment Bill (2016) proposes to remove the criminal offences in sections 224-226 of the Criminal Code (As at time of publication this Bill has not yet been passed).

For a person to be entitled to the defence 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 preservation of the mother's life encompasses 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[94].

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[92] *Warm Water Immersion during Labour and Birth*, C-obs 24, July 2008, (reviewed February 2021), The Royal Australian and New Zealand College of Obstetricians and Gynaecologists College Statement https://ranzcog.edu.au/wp-content/uploads/2022/05/Water-immersion-during-labour-and-birth.pdf

[93] *The Criminal Code Act 1899* (Qld) Schedule 1, s224 to s226.

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

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.

Refer to the Queensland Maternity and Neonatal Clinical Guideline: Termination of pregnancy, for further information, including the importance of provision of counselling and psychological support to women undergoing a termination of pregnancy[95].

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

- the patient has capacity
- 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 woman's life or her physical or mental health exists
- 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)[96] requires the Queensland Civil and Administrative Tribunal (not a substitute decision-maker or legal guardian) to provide consent to a termination of pregnancy as a matter of special health care.

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.

[95] Queensland Maternity and Neonatal Clinical Guideline: Termination of Pregnancy https://www.health.qld.gov.au/__data/assets/pdf_file/0029/735293/g-top.pdf

[96] *Guardianship and Administration Act 2000* (Qld) s71

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 developed after this Guide should be followed.

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 health care options, risks, complications and outcomes with the patient until the day of procedure.

Open access units are usually supported by nursing and other health care staff who provide extensive information (such as explanatory leaflets) to patients regarding their prospective health care. 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 and 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 Health care administered in a clinical trial, medical research or experimental health care

All medical research in Queensland requires ethics approval. The Department of Health Research Management Policy clearly outlines the consent requirements to be obtained from participants. Visit: https://www.health.qld.gov.au/system-governance/policies-standards/doh-policy/policy/qh-pol-013.pdf

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

There is a tension between providing health care 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 *Section 1.6: What process of informed decision-making needs to be followed?* and *Section 3: Informed decision-making and consent for children and young persons*, will apply.

Where general consent is obtained to participate in a program involving multiple health care episodes over a period of time, confirmation of ongoing consent is required on each occasion a patient attends for health care (see *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 health care 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 health care 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) are documented in the patient's

clinical record (see *Section 1.9: Can a patient or decision-maker decline or withdraw consent to health care?*). 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 health care, as described in *Section 3.1.8: Do parents or guardians need to be present at the time of health care 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 is required. Similarly, where older children and young persons lack capacity to consent to a specific form of health care 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?* provides more details about whether other people are able to consent or not.

If a child is brought for health care 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 health care 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 health care to children and young persons*.

Approved foster carers and approved kinship carers are able to consent for examinations and minor low risk health care 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 health care 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 health care with significant or long-term consequences or greater risks that would not be considered a matter of daily care (see *Section 3.1.3: What about children who are placed in care?*).

Where the specific health care provided will depend on the results of an initial examination, the initial consent is limited to the examination and additional consent to provide specific health care 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 health care 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 health care

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[97], or detention, medical examination and treatment by order of a magistrate[98] of persons with a controlled notifiable condition[99], 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[100].

[97] *Public Health Act 2005* (Qld) s112 to s115

[98] *Public Health Act 2005* (Qld) s116 to s 142

[99] *Public Health Regulation 2005* (Qld) Schedule 1

[100] *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 (known as 'off-label'), 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. Visit: https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/medicines/approved-list/default.asp 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.[101]

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[102].

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) 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 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.

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[101] *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 https://www.nswtag.org.au/wp-content/uploads/2017/07/off-label-use-sept-2003.pdf

[102] 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.

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

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

The informed decision-making processes associated with the obtaining of organs for transplantation is covered in the *Transplantation and Anatomy Act 1979* and these should be followed. This Act lists who is eligible, in order of priority, to give consent for organ and tissue donation. The Australian Organ Donor Register, managed by the Commonwealth Department of Health and Aging, is also interrogated on each donation episode to identify whether a written consent or objection to donation has been prepared by the deceased during their lifetime.

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 health care 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:

- Office of the Chief First Nations Health Officer
- Queensland Family and Child Commission
- Office of the Public Guardian
- Department of Child Safety, Seniors and Disability Services
- Queensland Civil and Administrative Tribunal
- Interpreter Service
- Office of the Chief Psychiatrist

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 last page of this Guide to obtain useful contact details for the advice provided above.

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

5.1 What about patients who have additional communication needs?

When a patient has limited health literacy, low or no English proficiency, has visual or hearing impairment, or has an intellectual or cognitive 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.

It is suggested that allocating sufficient time for discussions with the patient, and ensuring they do not have to wait, will assist in alleviating anxiety and reducing possible agitation.

Patients with an intellectual disability who are verbal may use masking strategies to hide what they don't understand. For example, by saying "aha", or by saying "yes", when this may not be the case. Consequently health practitioners may overestimate how much the person understands. 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

A careful assessment of a patient's capacity to make informed health care decisions will need to be made (see *Section 1.7: Is this adult patient able to make a decision about health care 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 health care and the consequences of accepting or declining the proposed health care options. However, low English proficiency does not in itself indicate low literacy, education or intelligence.

It is important to ensure that 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[103].

Refer to the current Queensland Language Services Policy visit: https://www.des.qld.gov.au/multicultural-affairs/policy-governance/language-services-policy

and Language Services Guidelines. Visit: https://www.communities.qld.gov.au/resources/multicultural/policy-governance/lsp-guidelines.pdf in relation to the use of interpreters.

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 health care 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.

[103] Refer to the current Queensland Language Services Policy https://www.des.qld.gov.au/multicultural-affairs/policy-governance/language-services-policy

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

The current Queensland Language Services Policy "*reflects the Queensland Government's commitment to the development of whole-of-government communication strategies that address language barriers*" This policy as well as the Guidelines that accompany it outline that:

Queensland Government agencies:

- will work with qualified interpreters as much as possible and develop a plan to ensure that services can still be delivered in circumstances where a qualified interpreter is not available
- ensure that interpreters who are not qualified should not be engaged unless the situation is an emergency and a qualified interpreter is not available
- be aware that friends and family members should not be used as interpreters, and children and young relatives are not appropriate interpreters in any context [104]

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 must be 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 is 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.

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:

- they have 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/)

[104] https://www.des.qld.gov.au/multicultural-affairs/policy-governance/language-services-policy

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 a third party.

From a legal aspect, the principles and requirement for informed consent to health care are essentially the same for all Queensland Health patients, regardless of their background, and individuals give their own consent to health care 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 and patients who identify as coming from an Aboriginal and Torres Strait Islander background might affect the treating relationship and communication around health care decisions to accommodate patients' varied needs. This may mean patients require assistance, or more time for appropriate family members, or 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 patients from CALD backgrounds by providing information that enables these 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 must 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 health care?

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 should be 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 in making a decision, after the health practitioner has 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 health care 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, 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 side effects, for fear of giving insult. Some patients from CALD backgrounds may also feel ashamed or embarrassed that they do not understand which may prevent them from communicating that they do not understand. This can also apply to Aboriginal and Torres Strait Islander patients (refer to *Section 5.4: What are the consent issues for Aboriginal and Torres Strait Islander patients?* for further information).

Where a health practitioner has doubts about the validity of a health care 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, those from a refugee background) may be resistant and mistrustful of mainstream services, authority figures, and hospitals. This may be expressed by them declining consent to health care or demonstrating a 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 country of origin or because they have 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 of patients from CALD backgrounds 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 health care
- 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 health care. 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 health care.

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 practice and is it something I need to take into account in my treatment plan?)
- adopt culturally appropriate and collaborative ways of working to empower patients from CALD backgrounds
- adopt culturally appropriate and collaborative ways of working with 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 health care, any potential adverse effects or interactions, whilst negotiating the health care to be provided and ensuring 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 health care 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 (see also *Section 1.9: Can a patient or decision-maker decline or withdraw consent to health care?*).

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

The following has been drafted with the assistance of the Aboriginal and Torres Strait Islander Health Division. Visit http://qheps.health.qld.gov.au/atsihb/home.htm

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 include:

- 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 health care 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, by 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 health care?*

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 health care 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: When consent isn't required for an adult who has impaired capacity to consent*, 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 health care, or leaves the health facility, the general principles in *Section 1.9: Can a patient or decision-maker decline or withdraw consent to health care?* 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 health care but unwilling to sign 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)

Glossary

Term	Definition	Source	See also
Adult	A person who is 18 years of age or older.		
Advance Health Directive	A document written by an individual over the age of 18 years, who has capacity, and which formalises their wishes about future health matters. It may also nominate one or more persons as a health attorney to make decisions on their behalf should the individual become unable to do so. It is only effective when the individual lacks capacity. A valid Advance Health Directive has the same effect as if the patient gave the directions when they had capacity.	*Powers of Attorney Act 1998* (Qld) s35. *Guardianship and Administration Act 2000* (Qld) definition of advance health directive in Schedule 4.	
Capacity	Capacity is specific to a particular decision and means the health practitioner has assessed the person to have capacity to consent, where the person has the ability to: *(a) understanding the nature and effect of decisions about the matter; and* *(b) freely and voluntarily making decisions about the matter; and* *(c) communicating the decisions in some way.'* It also includes the health practitioner's assessment of the patient's ability to retain the information and process it to reach a decision.	*Powers of Attorney Act 1998* (Qld) definition of capacity in Schedule 3. *Guardianship and Administration Act 2000* (Qld) definition of capacity in Schedule 4. *Mental Health Act 2016* (Qld) the definition of capacity in Schedule 3.	
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 health care.	*Child Protection Act 1999* (Qld) who is a child, s8.	Minor Young person

Term	Definition	Source	See also
Clinical incident	Any event or circumstance which has actually, or could potentially, lead to unintended and/or unnecessary mental or physical harm to a patient. Clinical incidents include adverse events (harm caused) and near hits/misses (no harm caused).	Best Practice Guide to Clinical Incident Management (2023) https://qheps.health.qld.gov.au/__data/assets/pdf_file/0038/637679/guide.pdf	
Clinical Incident Management System – RiskMan	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, May 2021	
Competence	In publications about patient consent, the terms 'competence' and 'capacity' are often used interchangeably. However the following difference applies: • A patient's 'competence' to make decisions is determined by a court. • A patient's 'capacity' to make decisions is determined by a health practitioner after a clinical assessment (see capacity above).		Gillick competence
Decision-maker	The patient or other person with the authority to make a decision whether to consent to or decline health care. For adults, substitute decision-makers are defined in the *Guardianship and Administration Act 2000* (Qld). For minors, the decision-maker will be a parent or guardian as defined in the *Family Law Act 1975* (Cth) or an individual appointed under the *Child Protection Act 1999* (Qld)	*Guardianship and Administration Act 2000* (Qld), the appointment of a guardian for a personal matter at s12. *Family Law Act 1975* (Cth), the definition of parent and guardian at s4. *Child Protection Act 1999* (Qld) types of child protection orders at s61.	Substitute decision-maker in the *Guardianship and Administration Act 2000* (Qld) defined at Schedule 4. See also s9 for the range of substitute decision-makers.
Delegate	Refer to health practitioner delegate.		Treating health practitioner Health practitioner delegate

Term	Definition	Source	See also
Dental practitioner	Dental practitioners include dentists, dental specialists, dental therapists, oral health therapists, dental hygienists and dental prosthetists.		
Dental treatment	Refer to health care.		Health care
Doctor	Refer to medical practitioner.		Medical practitioner
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.	*Powers of Attorney Act 1998* (Qld), the definition of enduring power of attorney at s32.	
Examination	Refer to health care.		Health care
Gillick competence	When a minor has the capacity to consent to health care, 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 health care, the consequences and risks of the health care that is proposed and the alternatives, including the consequences of not receiving the health care. 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	All health professionals who have the appropriate registration, accreditation, authority and expertise to assist patients in the process of informed decision-making. Examples include but aren't limited to persons registered as medical practitioners, dental practitioners, paramedics, pharmacists, midwives, midwife practitioners, nurses, nurse practitioners, allied health professionals such as physiotherapists and radiotherapists, and dental or oral health therapists. Currently, not all allied health professionals are registered, for example, social workers and dieticians. These types of health professionals work in relationship with and/or under the supervision and direction of health practitioners, but are required to adhere to the policy within their own defined scope of practice. Some other health care professionals who are unregistered and have authority and expertise include Aboriginal and Torres Strait Islander health workers and linguistic interpreters. 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.		Treating health practitioner Health practitioner delegate Australian Health Practitioner Regulation Agency (www.ahpra.gov.au) Office of Health Practitioner Registration Boards (OHPRB) http://www.archivessearch.qld.gov.au/Search/AgencyDetails.aspx?AgencyId=10447
Health practitioner delegate	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, sonographer, physiotherapist, registered nurse, nurse practitioner, oral health or dental therapist.		Delegate

Term	Definition	Source	See also
Health care	The term health care is care or treatment of, or a service or a procedure for, the adult to diagnose, maintain or treat the adult's physical or mental condition and carried out by, or under the direction or supervision of, a health provider. For example, • 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 below, 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. 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.	*Guardianship and Administration Act 2000,* Schedule 2, s5(2).	Dental treatment Medical treatment Invasive procedure
Impairment	Means a cognitive, intellectual, neurological or psychiatric impairment.		
Impaired capacity	Means the person does not have capacity for the matter.	*Powers of Attorney Act 1998* (Qld), Schedule 3. *Guardianship and Administration Act 2000* (Qld), Schedule 4.	

Term	Definition	Source	See also
Informed consent	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 health care, 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 health care. 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.		
Invasive procedure	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 the mouth. It also includes investigations such as endoscopy and transrectal or transvaginal ultrasound.	*Public Health Act 2005* (Qld), s147	Health care
Investigation	Refer to health care above.		Health care
Legal guardian	A person appointed under the *Family Law Act 1975* (Cth) or appointed under the *Child Protection Act 1999* (Qld) who has the legal authority to consent on behalf of a child or young person.	*Family Law Act 1975* (Cth) *Child Protection Act 1999* (Qld) s61	
Material risk	Within this suite of documents, 'material risk' refers to the information about the risks of health care that: • 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 health care 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 health care.	Adapted from Rogers v Whittaker (1992) 175 CLR 479 (High Court of Australia) *Civil Liability Act 2003* (Qld) s21 NB the Act and the case impose duties on doctors.	
Medical officer	Refer to medical practitioner immediately below.		

Term	Definition	Source	See also
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'.		See *Section 1.12.*
Medical treatment	Refer to health care above.		Health care
Minor	An individual under the age of 18 years.	*Child Protection Act 1999* (Qld) s8.	Child Young person
Midwife	A person registered and licensed as a midwife by the Nursing and Midwifery Board of Australia.		See *Section 1.12.* 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.		See *Section 1.12*. 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.		
Parent	Means a person with parental responsibility for a child or young person, such as a natural parent, adoptive parent, guardian, or someone who is the subject of a parenting order for the child under the *Family Law Act 1975* (Cth). More than one person may have parental responsibility. With respect to Aboriginal and Torres Strait Islander peoples who are in the traditional role of a parent: refer to section 61F of the *Family Law Act 1975* which provides guidance on the meaning of parent for both Aboriginal and Torres Strait Islander peoples.	*Family Law Act 1975* (Cth) s4 *Hospital and Health Boards Act 2011* (Qld) s140	Parent

Term	Definition	Source	See also
Patient	The term 'patient' refers to the patient or other person who is legally able to make a decision on behalf of the patient. 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 way as the patient. For a child or young person this might be a parent or legal guardian. For an adult this might be a substitute decision-maker as defined within the *Guardianship and Administration Act 2000* (Qld). Synonyms for 'patient' include client or customer.		Decision-maker
Patient-centred care	The delivery of health care that is responsive to the needs and preferences of patients. Patient-centred care is a dimension of safety and quality. 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.	National Safety and Quality Health Service Standards, June 2011	
Procedure	A component of health care.		Health care
Restrictive Practices	Restrictive practices in health care are practices or interventions that have the effect of restricting the rights or freedom of movement of a person and are primarily used for the intent of protecting that person or others from harm. Note, this excludes the application of restraints or other uses of force by Queensland Police Service and/ or Queensland Corrective Services under their legislative frameworks.	Minimising restrictive practices, Department of Health Policy *(awaiting publication)*	

Term	Definition	Source	See also
Sight translation	Rendering a verbal interpretation of a written message (reading in one language, relaying messages orally in another language).		
Social coercive influences	In the context of a patient giving consent for a trainee/student health practitioner to provide health care to a patient under appropriate supervision: it must be clear that the consent given is voluntary and free from influence. For example if the patient is asked to consent in the presence of a trainee/student, and chooses to decline their involvement, the patient must be reassured that the decision to decline will not detrimentally affect their health care.	There is no dictionary definition per se	
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	
Special health care matter	Health care of the following type: • 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 health care • electroconvulsive therapy or a non-ablative neurosurgical procedure • care prescribed under the *Guardianship and Administration Act 2000* (Qld).	*Guardianship and Administration Act 2000* (Qld) Schedule 2, s7.	

Term	Definition	Source	See also
Statutory Health Attorney	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: • a spouse of the adult patient if the relationship is close and continuing • a person who is 18 years or over and who has the care of the adult patient (but is 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 public guardian.	*Powers of Attorney Act 1998* (Qld) s62 to s63.	Substitute-decision-maker
Student health practitioner	Someone enrolled in an approved program of study.		Trainee See also Social coercive influences
Substitute decision-maker	The person who is legally entitled to give consent to health care 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 See also social coercive influences

Term	Definition	Source	See also
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 See *Section 1.12*.
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 health care.		Treating health practitioner See *Section 1.12*.
Treatment	A form of health care.		Health care
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 health care.		Minor Child

Interpretation

The following rules apply in interpreting this Guide, unless the context otherwise requires:

(i) 'such as',
(ii) 'including'
(iii) 'for example'

are used in this Guide to illustrate a sample scenario and are not intended to be a full and exhaustive list of possibilities.

Table 1 Version history

Version	Date	Changes
Version 2.2	18 December 2023	• Update *Sections 1.6.3* and *1.6.7* to include the recommendations from a recent Coronial Inquest findings, specifically: • *Section 1.6.3* update paragraph: For a patient, consumer or a resident who has a substitute decision maker, an enduring Power of Attorney or a Statutory Health Attorney, the decision maker is to be given the same information as would be expected to be given to the person if they were providing consent for themselves. Details of the consenting individual and any legal instruments should be documented in the appropriate section of the consent form. • *Section 1.6.7* update bullet points: ◦ substitute decision maker/s present ◦ the material risks and benefits of the proposed health care and/ or withheld treatment discussed for that individual patient ◦ date and time of discussion/s, any concerns raised, and decisions for/against ◦ date and time when the consent was recorded, noting substitute decision-maker/s when applicable ◦ documentation of consent to treatment/withholding of treatment by relevant decision-makers
Version 2.1 *interim update*	5 December 2023	• Update sections to align with the *Mental Health Act (MHA*) 2016 (Qld) • Update *Section 2.2.6* to align with the *MHA* 2016 and to include sub-sections other key legislation: *Disability Services Act 2006* (Qld), *Guardianship and Administration Act 2000, Aged Care Act 1997* (Cth) and *Quality of Care Principles 2014; National Disability Insurance Scheme (NDIS) Act 2013* (Cth) and *NDIS (Restrictive Practices and Behaviour Support) Rules 2018* (Cth) • *Sections 1.6.4, 1.7, 2.1, 4.2 to include* ◦ *person's Nominated Support Person'; MHA definition and assessment of 'capacity' differs to other Queensland statutory definitions; 'non-ablative neurosurgical procedure'* • *Section 2.2.5* ◦ Update title to '*Advance Health Directives and the Mental Health Act 2016'* • *Section 2.2.6 (previously 2.3.2)* ◦ Update title to '*Can the use of force and restrictive practices (including physical restraint and sedation) be justified when providing health care to adult patients who lack capacity to make a decision*' ◦ Previous title *'Use of restrictive practices when providing health care to adult patients who lack capacity to consent'* ◦ Include 'restrictive practices' and remove reference to 'chemical restraint' • *Section 2.2.7* ◦ Update title to *' 'Special health care' that requires the consent of a Tribunal or Court for adult patients who lack capacity'* • *Sections 2.2.5, 2.2.6, 2.2.7, 4.2* ◦ Update to reflect use of 'less restrictive way' to gain consent, other than treatment provided without consent under the *MHA* • *Sections 2.2.7, 4.2*

		○ Update content on electroconvulsive therapy (ECT) and a non-ablative neurosurgical procedure as 'regulated treatments' under the *MHA* • *Section 4.12*- update titles of *Department of Child Safety, Seniors and Disability Services, Office of the Chief First Nations Health Officer and the Office of the Chief Psychiatrist* • Glossary- update *MHA* reference in 'capacity'; add 'restrictive practices' • *Appendix 1*- update contact details for Child Safety, QCAT, Mental Health Act Liaison Service, Office of the Chief Psychiatrist

Appendix 1

Useful contact details

Aboriginal and Torres Strait Islander Health Division

Email: fnho_strategy@health.qld.gov.au

Department of Child Safety, Seniors and Disability Services (Child Safety)

Postal address: GPO Box 806
Brisbane QLD 4000
Free call: 1800 811 810 (Queensland only)
Phone: +61 7 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 4001
Phone: 1300 753 228
+61 7 3328 4046
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 Service

Office of the Chief Psychiatrist
Department of Health
Business hours: Monday to Friday 8:30am – 4:30pm
Free call: 1800 989 451
Phone: +61 7 3328 9899
Website: www.health.qld.gov.au/mental-health-act
Email: MHA2016@health.qld.gov.au

Multicultural Health

Multicultural Affairs Queensland (MAQ),
Department of Environment and Science
Phone: +61 7 3097 7712
Email: Secretariat.MAQ@des.qld.gov.au
Website: https://www.des.qld.gov.au/multicultural-affairs

Office of the Public Guardian

Postal address: Department of Justice and Attorney General
PO Box: 13554 George Street Brisbane 4003.
Phone: 1300 753 624 (Health Care Decisions)
Phone: +61 7 3239 6298
Email: adult@publicguardian.qld.gov.au or child@publicguardian.qld.gov.au

Office of the Public Advocate
Phone: +61 7 3224 7424
Email: public.advocate@justice.qld.gov.au