Government of Western Australia
Department of Health

Policy Frameworks
MP 0175/22
Effective from: 13 March 2023

Consent to Treatment Procedure

1. Purpose

The purpose of the *Consent to Treatment Procedure* is to outline the processes that must be followed to comply with the mandatory requirements of MP 0175/22 *Consent to Treatment Policy*.

2. Applicability

This Procedure applies to all health practitioners that provide treatment on behalf of the WA health system, and those who admit patients to a public hospital from their private rooms irrespective of whether the patient is to be admitted as a public or private patient.

This Procedure does not cover consent relating to matters other than treatment (e.g. Financial consent, collecting or disclosing information, clinical trials and other medical research, photography or filming). Please see *NSQHS Advisory 18/10 Informed Financial Consent.*

3. Procedural Requirements

3.1 Explicit Consent

Explicit consent must be sought and documented prior to:

- Proceeding with any of the following treatments[1] (other than in an emergency or where another exception applies (see section 3.7 of the Policy)) that require general, spinal, epidural or regional anaesthesia and intravenous sedation:
  - surgical
  - medical
  - dental
  - radiology
  - endoscopy
  - obstetric
  - oncology
  - mental health
- blood transfusions or the administration of blood or blood products
- any invasive treatment where there are known significant risks or complications
- student health practitioner involvement in treatment (e.g. conducting intimate examinations on anaesthetised patients).
- commencement of medications with known high-risk complications including clozapine, mifepristone, thalidomide, lenalidomide and pomalidomide
- Therapeutic Goods Administration off-label use of therapeutic devices
- commencement of medications:
  - under the Special Access Scheme

  or
  - for investigational purposes.

[1] *other than in certain circumstances as listed in section 3.6

If prescribing medicines for off label use, then the principles of the Council of Australian Therapeutic Advisory Groups 'Guiding Principles for the quality use of off-label medicine 2013' should be followed.

The explicit consent process can occur over several discussions between the health practitioner(s) and patient regarding the proposed treatment. Where possible, these discussions must be conducted face-to-face. If this is not practicable, telehealth may be permitted however, the health practitioner must determine whether the use of telehealth is appropriate taking into consideration the patient's circumstances and any legislative requirements (i.e. mental health legislation).

The consent process must adhere to the following steps in the table below. Further information is provided in sections 3.2 – 3.6.

Table 1: Explicit Consent Process

Step	***Instruction***	
1.Determine which health practitioner is responsible for seeking consent	Where a team of health practitioners are responsible for a patient, each health practitioner may be providing information to the patient that is relevant to their consent decision. The health practitioner ultimately responsible for providing treatment (e.g. lead surgeon, a physician leading the team) must be satisfied that the consent process has been properly undertaken and the patient has reached a decision to provide or withhold consent to the proposed treatment.	
2. Assess the patient's capacity relevant to the treatment decision to be made	Patient has capacity • Adults are presumed to have capacity unless there are reasonable grounds to conclude otherwise. • Older children may be assessed as a 'Mature Minor' in respect of a particular proposed treatment.	Patient does not have capacity • If an adult patient does not have capacity, follow the WA Hierarchy of Treatment Decision-Makers to determine the most appropriate pathway as per the *Guardianship and Administration Act 1990*. • All children are assumed not to have capacity by virtue of their age and immaturity. • If a child is not a 'Mature Minor' then the child's parent or legal guardian may make the treatment decision subject to the *parens patriae* powers of the Court
3. Communication regarding proposed treatment so the patient / substitute decision maker can make an informed decision	To assist the patient to make an informed decision regarding consent, the health practitioner must (within their scope of practice): • explain the proposed treatment (including treatment and recovery period), the potential benefits, complications, material risks as relevant to the patient's particular situation and the possibility the treatment may be unsuccessful. • inform the patient of alternative treatment options and the option to seek a second opinion.	

	• allow the patient opportunities to ask questions about the proposed treatment and receive any further information they require before making a decision • respond to all patient queries with meaningful answers specific to the patient's situation. Information provided must be appropriate in terms of the patient's language and communication needs, health literacy and culture. When there is a person responsible for providing consent on behalf of a patient, they must be provided the same information as would have been given to the patient if they had the capacity to make the treatment decision.
4. Verify that the patient / substitute decision maker understands the information given and all their queries have been addressed	Health professionals must be satisfied that the patient understands the information presented and that all their queries have been addressed. They can do this by verifying that the patient: • understands the effect of the treatment decision • understands that a choice can be made • has had sufficient time to consider and clarify the information presented • can communicate key information about the proposed treatment and their decision back to the health practitioner. Where there is uncertainty about English proficiency or other language barriers, language services must be engaged. Relevant services must also be engaged for patients with disabilities such as hearing or sight impairments.
5. Seek a decision from the patient / substitute decision maker about the proposed treatment	The patient's consent must be sought (and documented) prior to providing treatment. Any patient with capacity, or a person authorised to make a decision on their behalf, has the absolute right to accept, decline or refuse a proposed treatment. At any time before the treatment has been provided; consent may be withdrawn. Some treatments can involve more than one treatment as part of a course and the consent process can cover all of those treatments.
6. Document consent	Health practitioners must document consent either in a consent form or the patient's medical record (where a consent form is not available. Please refer to policy section 3.5 for the information required to document consent.

A patient's consent remains valid until either the patient withdraws it, or the proposed treatment is no longer appropriate due to a change in the patient's circumstances.

Examples of changed circumstances include:

- An improvement or deterioration in the patient's condition (e.g. a change from cure to palliative goals or a new diagnosis)
- Development of new treatment options since consent was given.

3.2 Assessing Capacity

3.2.1 Adults

An adult has capacity to give consent if they can understand the nature, consequences and risks of the proposed treatment. The following principles must be considered when assessing a person's capacity:

- Capacity can be lost and regained. Though incapacity may be permanent in some cases, in other cases it will be temporary, for example if a patient regains consciousness or if they are no longer affected by medication, pain or other substances.
- Capacity must be relevant to the treatment decision. A patient may have capacity to make decisions about simple treatments, but not have capacity to make decisions about more complex treatment. A child's level of maturity means that they may be a 'Mature Minor' for some treatment decisions but not necessarily all.
- It must not be assumed that a patient lacks capacity solely because of their age (except if they are a child), disability, behaviours, medical condition (including mental illness), beliefs or the fact that they disagree with a health practitioner.

If a patient does not have capacity, health practitioners must follow the WA Hierarchy of Treatment Decision-Makers to determine the most appropriate pathway as per the *Guardianship and Administration Act 1990*.

Where there is more than one person in the same level of the hierarchy of treatment decision-makers who wish to be involved and those persons cannot agree on the treatment decision, the health practitioner must encourage them to reach consensus. If this cannot be achieved, these people may need to seek an order for guardianship from the State Administrative Tribunal.

If a 'substitute decision-maker' cannot be identified, an application can be made to the State Administrative Tribunal for appointment of a Guardian.

3.2.2 Children and Mature Minors

Children are assumed not to have capacity for consent. Where possible, children should be supported to participate in discussions and decision-making about their treatment, even where they do not have the capacity to make final decisions.

Generally, as a child gets older, their intellectual and emotional maturity and competence to understand information relevant to a proposed treatment increase. Older children should be assessed to determine if they have the capacity, as a "Mature Minor" to make a decision about the proposed treatment. There is no specific age at which a child becomes a 'Mature Minor'. An assessment of a child as a 'Mature Minor' must be made in the context of the proposed treatment, that is, maturity in relation to one treatment decision does not necessarily equate to maturity for all treatment decisions.

3.2.3 Patients with Mental Illness

The treatment of patients with mental illness is governed by the *Mental Health Act 2014*. Adult patients with mental illness must be assumed to have capacity, and children are assumed not to have capacity unless the child is shown to have capacity. Requirements for informed consent relating to patients with mental illness are set out in Part 5 Division 1 of the *Mental Health Act 2014.*

Supporting resources for assessing capacity includes the WA clinician consent to treatment flowchart "Can your patient consent to treatment?"

3.3 Exchange of Information

The exchange of meaningful information between the health practitioner and patient is vital to informed decision making. Health practitioners must attempt to find out what is important to the patient: their needs, culture, values, beliefs, and priorities, so they can share relevant information about the benefits and material risks of proposed treatment options and reasonable alternatives, including the option to take no action.

Information relevant to a treatment decision may be provided by the health practitioner across many consultations, as more information may come to light about a patient's condition, change in personal situation and treatment options. This provides an opportunity for health practitioner to have several discussions with the patient regarding the proposed treatment and for the patient to discuss the treatment with their support networks and think about any further information they might need to help to make the decision.

Patients must be given written information such as procedure specific information sheets about their proposed treatment, where available and where the patient's literacy has been considered. The provision of written information must not be used as a substitute for a face-to-face (or telehealth) discussions. Health practitioners must be aware that pre-prepared information sheets usually refer to the risks facing an "average" patient having the treatment and this detail may be insufficient to cover a particular patient's circumstance. In these cases, additional information must be provided to each patient based on their individual needs and risk factors.

If a patient advises that they wish to decline written information offered about their treatment options, this must be documented in their medical record. Where this occurs the health practitioner must still be satisfied that the patient understands the benefits and material risks of the proposed treatment prior to accepting that valid consent has been given and proceeding to provide the treatment.

All patients have the right to be heard and to ask questions about any information provided regarding the proposed treatment. In addition to the provision of information, patients must be afforded time and support to understand the information presented. This can include the provision of information written and/or translated into an appropriate language, use of decision aid tools, and engagement of the patient's support networks (including family and involved health practitioners). The teach-back methodology is encouraged, where possible, to ensure the patient understands the information provided. This method is a way of checking understanding by asking patients to state in their own words what they know including the benefits and material risks regarding the proposed treatment.

Patients who have difficulties communicating in written and/or spoken English may require support from language services. This includes people who are deaf, hard of hearing, Aboriginal

people and those from culturally and linguistically diverse backgrounds. Where a patient is identified as having special language requirements, the health practitioner must not rely on family members or friends for consent discussions. They must engage the services of a professional interpreter in accordance with the *MP 0051/17 Western Australian Language Services Policy*. In these situations, the onus remains on the clinician to seek and document consent. Aboriginal patients should be offered to the option to speak to an Aboriginal Liaison Officer.

Vision impaired resources must be made available for patients with vision impairment.
When there is a substitute decision maker responsible for providing consent on behalf of a patient, they must be given the same information as would have been given to the patient if they had the capacity to make the treatment decision.

3.4 Documenting Consent

Key points from discussions regarding the proposed treatment and consent decisions must be documented regardless of whether the patient consents to, declines or withdraws consent to the proposed treatment. The consent form must be used to document this information. Where a consent form is not available, the patient's medical record can be used. The documentation of specific details is particularly important where the treatment or procedure is complex or has high risk of adverse outcomes. All consent documentation must be stored in accordance with the *State Records Act 2000*.

If consent is gained through a substitute decision maker, then the consent process must be followed, and the reasons for why the patient cannot provide consent must be documented.

Health Service Providers must provide consent forms to be used by health practitioners. However, completing a consent form is not a substitute for a meaningful discussion tailored to the individual patient's needs and will not necessarily be conclusive evidence that consent was properly obtained.

Where telehealth has been used for consent discussions, the consent process must still occur in full. The health practitioner that undertook the consent discussion must annotate the consent form on behalf of the patient, noting that the discussion occurred via Telehealth. This consent must be confirmed with the patient's own signature (or that of their substitute decision maker) prior to treatment commencing.

Electronic signatures of the health practitioner or patient are acceptable on electronic consent form providing:

- they clearly identify the signatory and their intention to sign
- the method of identification must be considered reliable for obtaining consent; and
- the patient must agree to the use of electronic signatures.

All HSPs must ensure there is clear governance regarding the use of electronic signatures. Please refer to the *Electronic Transactions Act 2011*.

Abbreviations or acronyms may be used on consent forms providing the term is spelled out in full when first stated.

3.5 Decline or Withdrawal of Consent

If a patient with capacity declines a particular treatment or component of treatment, their decision must be respected, and the health practitioner must not proceed with the treatment. The patient should be encouraged to seek a second opinion (if relevant) and inform their family (and any potential substitute decision makers) who may be responsible for making treatment decisions in the future.

If a patient with capacity consents to treatment and then subsequently withdraws their consent, the health practitioner should discuss that decision with the patient. This discussion should include information about risks and alternative treatment(s). The treatment must not commence, or if it has already commenced, it must cease immediately (if practicable). The date of withdrawal and any relevant circumstances must be documented in the patient's medical record. The patient must be encouraged to inform their family (and any potential substitute decision makers) who may be responsible for making treatment decisions in the future.

3.6 The Law Either permits or Forbids Treatment

The following legislation allows or forbids treatment regardless of whether the patient or substitute decision maker has provided consent:

- *Road Traffic Act 1974* – samples of blood and urine can be taken on motor vehicle accident patients without their consent.
- Human Tissue and Transplant Act 1982 – provides specifically for blood transfusions on children without parental consent (in stated circumstances).
- *Prisons Act 1981* – medical officers may provide medical treatment to prisoners who refuse it in certain circumstances (where the medical officer is of the opinion that the life or health of the prisoner or any other person is likely to be endangered by that refusal).
- *Guardianship and Administration Act 1990* – where a patient's interests are represented by a guardian, that guardian cannot, on their own, consent to the patient undergoing sterilisation.
- *Mental Health Act 2014* – involuntary patients and mentally impaired accused patients can be provided with some treatment, in specified circumstances, for the purposes of addressing their mental health impairment, without informed consent.
- Supreme Court acting in its parens patriae jurisdiction can authorise some treatments on children without parental consent. This requires the Court to determine whether or not the proposed treatment is in the child's best interests, e.g. sterilisation, gender reassignment surgery.

3.7 Referral for legal advice

Where health service providers or health practitioners require legal advice in relation to consent for treatment, they must refer to MP0023/16 *Obtaining Legal Advice*. Noting that such cases can be urgent and complex, early referral is suggested.

This document can be made available in alternative formats on request for a person with a disability.