Disclaimer

The information contained in this document is not intended to be comprehensive and it should not be relied upon as a substitute for legal advice or other professional advice.

The law is dynamic and while every attempt is made to ensure the content is accurate, complete and up-to-date, it cannot be guaranteed.

If you have a legal problem you should seek legal advice tailored to your specific circumstance from the Legal and Legislative Services Directorate of the Department of Health Western Australia (or the State Solicitor's Office in the case of teaching hospitals only) before acting or relying on any of the legal information in this policy.

Consent to Treatment Policy for the Western Australian Health System 2011

The Consent to Treatment Policy for the Western Australian Health System may be updated at regular intervals. For the latest version of this document, please visit the Office of Safety and Quality in Healthcare’s website at: www.safetyandquality.health.wa.gov.au.

The Consent to Treatment Policy for the Western Australian Health System is protected by copyright. Copyright resides with the State of Western Australia. Apart from any use permitted by the Copyright Act 1968 (Cth), no part of this document may be published, or reproduced in any material form whatsoever, without the permission of the Office of Safety and Quality in Healthcare, Performance Activity & Quality Division, Department of Health.

For further details please contact:
Office of Safety and Quality in Healthcare
Performance Activity & Quality Division
Western Australian Department of Health
189 Royal Street, East Perth Western Australia 6004

Tel: (08) 9222 4080
Fax: (08) 9222 2032
Email: safetyandquality@health.wa.gov.au
Website: www.safetyandquality.health.wa.gov.au
Acknowledgements

The WA Council for Safety and Quality in Health Care and the Office of Safety and Quality in Healthcare, Department of Health, would like to acknowledge the valuable work of the New South Wales Department of Health in developing the *Patient Information and Consent to Medical Treatment Policy*. The New South Wales Health Department has approved the use of its policy as a model for developing the Consent to Treatment Policy for the Western Australian Health System.

The WA Council for Safety and Quality in Health Care and the Office of Safety and Quality in Healthcare also acknowledges and appreciates the input of all individuals and groups who contributed to the development and review of the policy. Those involved in the development of this third edition include:

Safety and Quality Executive Advisory Committee
Clinical Governance Network
Office of the Chief Medical Officer
Office of the Public Advocate
Legal and Legislative Services at the Department of Health
Policy Officers Network of WA Health
North Metropolitan Area Health Service
South Metropolitan Area Health Service
WA Country Health Service
Office of the Public Advocate.
Foreword

In October 2000, the Department of Health issued guidelines on consent to treatment and disclosure of material risks. To assist health professionals meet their obligations under the 2000 guidelines, the Department of Health also support the use of procedure-specific information sheets for the most commonly performed procedures in public hospitals and made these available for use throughout the State.

Following feedback from health professionals across the WA health system, the Western Australian Council for Safety and Quality in Health Care (the Council) established the Informed Consent Advisory Committee in late 2004 (the Committee). This Committee made a number of recommendations to assist health professionals comply with the consent process.

On the basis of the Committee’s recommendations, the Department of Health’s Office of Safety and Quality in Healthcare developed the first edition of the Consent to Treatment Policy for the Western Australian Health System (the Consent Policy). This policy was released in October 2006.

Since 2006 this Consent Policy has been updated to include:

- reference to the suite of Procedure Specific Information Sheets available for use by health professionals in the WA public health system (second edition May 2009)

On behalf of the Health Department of WA, I am now pleased to introduce this third edition of the Consent to Treatment Policy for the Western Australian Health System.

I look forward to working in partnership with hospital and health service managers, service providers and consumers to ensure that this Consent Policy continues to be a key point of reference for health professionals across Western Australia’s public hospitals and health services.

Kim Snowball
DIRECTOR GENERAL
WA HEALTH
March 2011
Contents Page

1. Purpose of the Consent to Treatment Policy for the Western Australian Health System 1

2. What is meant by consent to treatment? 3

3. Why is it necessary to obtain patient consent? 4
   3.1 When should consent be obtained in writing? 4

4. When do different arrangements apply in obtaining consent 6
   4.1 Treatment in an emergency 6
   4.2 Provision of treatment under the Mental Health Act 1996 7
      4.2.1 Medical treatment 7
      4.2.2 Psychiatric treatment 7
      4.2.3 Emergency psychiatric treatment 8
   4.3 Adult patients unable to make reasonable judgments about treatment decisions - Guardianship and Administration Act 1990 8
      4.3.1 Advance Health Directives (AHDs) 9
      4.3.2 Treatment decisions by substitute decision makers 10
      Figure 1: Treatment hierarchy 14
      4.3.3 Urgent treatment 15
   4.4 Common Law Directives 15
   4.5 Treatment of a minor 16
      4.5.1 Emergencies 16
      4.5.2 Parental consent 16
      4.5.3 Exemptions to obtaining parental consent 17
   4.6 Treatment which is prohibited by law or which is prohibited unless certain requirements are met 18
   4.7 Other procedures where the usual process for obtaining consent may vary 19
      4.7.1 Anaesthesia 19
      4.7.2 Open-access procedures 20
      4.7.3 Obstetric procedures 20
      4.7.4 Blood products 21

5. How should consent be sought and obtained? 22
   5.1 What are the requirements for valid consent? 22
   5.2 What information should be given to a patient? 22
      5.2.1 How should a patient be informed about material risks? 24
      5.2.2 How information should be provided to a patient from a culturally and/or linguistically diverse background or who has special needs? 25
      5.2.3 Can pre-prepared information be given to patients? 26
   5.2.4 Can information be withheld from a patient? 28
   5.2.5 What if the patient does not want information? 28
6. Who is responsible for obtaining consent? 29
   6.1 Can another health professional obtain a patient’s consent to treatment? 29
      6.1.1 Can the consent process be delegated to another ‘uninvolved’ health professional or junior health professional 29
      6.1.2 Can nurses and other health professionals be involved in providing information and obtaining consent for procedures that are performed by medical practitioners? 30
      6.1.3 Can nurse practitioners and eligible midwives obtain consent for the treatment they perform? 30

7. How long is consent valid? 31
   7.1 Consent for a course of treatment e.g. chemotherapy 32

8. What if a patient refuses to consent to treatment? 33

9. How should the consent process be documented? 34
   9.1 What if the patient is admitted from the health professional’s private rooms? 34
   9.2 What if a patient arrives in the operating theatre without valid or documented consent? 34
      9.2.1 Emergency treatment 35
      9.2.2 Non-emergency treatment 35
   9.3 Generic consent to treatment forms 36
      9.3.1 Development of speciality consent forms 37

10. Governance responsibilities of hospitals in implementing of the Consent to Treatment Policy? 38

11. Definitions 39

12. Useful contacts and sources of information 44
Appendices

Appendix 1 FORM A Patient consent to treatment or investigation 46
Appendix 2 FORM B Consent for a minor requiring parental or guardian approval for treatment or investigation 48
Appendix 3 FORM C Adults unable to consent to treatment or investigation 50
Appendix 4 FORM D Patient consent to anaesthesia (general or regional) 52
Appendix 5 FORM E Consent form for electroconvulsive therapy 54
Appendix 6 FORM F Authorisation to proceed with surgery on a patient without a valid consent form 56
Appendix 7 Extracts from relevant legislation 57
   A. Criminal Code 1913 59
   B. Family Law Act 1975 (Commonwealth) 60
   C. Guardianship and Administration Act 1990 62
   D. Mental Health Act 1996 79
   E. Health Act 1911 83
   F. Human Tissue And Transplant Act 1982 86
   G. Civil Liability Act 2002 89
References 91

NOTE: This Consent Policy may be updated at regular intervals. For the latest version of this document, please visit the Office of Safety and Quality in Healthcare website at www.safetyandquality.health.wa.gov.au
1. Purpose of the Consent to Treatment Policy for WA Health

The Australian High Court case of Rogers v Whittaker (1992)¹ was a landmark decision that clarified the legal obligations and requirements for health professionals to obtain a patient’s consent to treatment.

The High Court held that the law ‘imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment and that the duty extends to the provision of information in an appropriate case’.¹ This decision applies to all health professionals.

The High Court also held that the ‘patient’s consent to treatment may be valid once he or she is informed in broad terms of the nature of the procedure which is intended’ but that ‘the choice is, in reality, meaningless unless it is made on the basis of relevant information and advice’.

As the High Court pointed out, ‘the skill is in communicating the relevant information to the patient in terms which are reasonably adequate for that purpose having regard to the patient’s apprehended capacity to understand that information’.¹

This Consent Policy aims to assist health professionals working within WA Health meet their legal obligations in seeking and obtaining consent. For the purposes of this Policy a health professional is a person defined as such in section 5PA of the Civil Liability Act 2002² (refer to Appendix 7G of this Consent Policy).

The third edition of the Consent Policy includes changes resulting from the introduction of the Acts Amendment (Consent to Medical Treatment) Act 2008³. The majority of these provisions came into effect on 15 February 2010.

As a result the Guardianship and Administration Act 1990⁴ includes provisions covering:

- Advance Health Directives
- the appointment of Enduring Guardians
- a revised treatment hierarchy where a substitute decision-maker is required.

References to the patient in this Consent Policy should be taken to include a substitute decision-maker.

The third edition also updates all legislative and other references. A list of key definitions is now provided at section 11 of this policy. This change has allowed for the removal of footnotes to improve readability thus providing easier access to key terminology.

Section 12 lists relevant contacts and sources for further advice and information.

Health professionals working within WA Health can obtain an electronic copy of this Consent Policy, associated consent forms and procedure specific information sheets from the Office of Safety and Quality in Healthcare website at:

The Consent Policy:

- requires a patient to be actively involved in the decision-making process
- requires WA hospitals/health services to take a patient-centred view of the consent process based on the premise that it is a patient’s right to determine what happens to his or her own body
- provides guidance for health professionals about the consent process
- outlines information that should be given to a patient to assist that person to make informed decisions prior to deciding on a course of action
- gives guidance for health professionals in situations where statute law governs how consent should be obtained
- provides advice on how patients should be informed about risks
- includes recommended Consent to Treatment forms for competent adults, mature minors and patients incapable of consenting to treatment (refer to Appendices 1 to 6 of this Consent Policy).

**Compliance with this Consent Policy is mandatory.** In order to accommodate local variation in patients and practices, hospitals/health services operating within WA Health will either adopt this Consent Policy in toto, or develop local operational consent policies that are aligned with this Departmental Consent Policy. Hospitals/health services within WA Health must also provide health professionals with:

- access to this Consent Policy
- the associated consent forms
- the related Operational Directive.
2. **What is meant by Consent to Treatment?**

Consent is a patient’s agreement for a health professional to provide treatment.

For the purposes of this policy *treatment* means any medical, surgical or dental treatment or other health care, including life-sustaining measure or palliative care.4

The consent process should be considered as a series of steps.

1. **Inform the patient about the proposed treatment**
   
   Provide the patient with all the information that will assist him or her to reach an informed decision; that is, whether or not to consent to the proposed treatment. The information must include a description of the proposed treatment and any material risks.1

2. **Ensure the patient understands the information given and all matters have been discussed**
   
   Effective dialogue and discussion is good practice and a fundamental part of the consent process. Make sure the patient:
   
   - understands and retains the information
   - believes the information (i.e. is not divorced from reality or is unable to comprehend what is being said)
   - understands that a choice can be made
   - is able to reason (however unreasonably) and make a choice.5

3. **Seek a decision from the patient about the proposed treatment**
   
   Seek the patient’s consent for the specific procedure. Subject to some specific exemptions it is always the patient’s right to determine whether or not to consent to receiving the treatment recommended by the health professional.6

4. **Record the patient’s decision about the proposed treatment**
   
   Record and document the consent process in the patient’s health care record. The documentation should include the date and time of the patient’s decision to consent, or to refuse consent, to the proposed treatment.

Obtaining a signature on a consent form formalises the process and should be done in all cases where practicable.

If the patient refuses to agree to the proposed treatment, it is essential that this refusal and the circumstances in which consent was refused are properly recorded in the patient's health care record (refer to section 8 of this Consent Policy).
3. Why is it necessary to obtain a Patient’s Informed Consent?

A health professional’s obligation to obtain consent is distinct from the obligation to disclose information to a patient and warn him or her of material risks. Simply obtaining a patient’s written consent does not mean that the legal duty towards a patient to explain all material risks has been fulfilled.

In *Rogers v Whittaker* (1992)¹ the High Court made it clear that a patient’s consent to treatment is meaningless unless it is made on the basis of relevant information and advice. A patient’s choice as to whether or not to undergo treatment requires a decision based upon information that will be known to the health professional but not to the patient.

Therefore, in addition to obtaining a patient’s consent, whether orally or in writing, a health professional has a legal obligation to fully inform the patient of the potential benefits of the procedure and of any material risks inherent in that procedure, including the possibility that the treatment may be unsuccessful.

Failure by the responsible health professional to obtain a patient’s consent for a procedure may result in that person facing a criminal charge of assault or civil action for battery. On the other hand a health professional’s failure to disclose material risks to a patient may give rise to civil action for negligence.

3.1 When should consent be obtained in writing?

It is Department of Health policy that all WA Health facilities (as expressed in this Consent Policy) will obtain written consent using an approved consent form, except for emergency treatment (refer to section 4.1 of this Consent Policy), for:

- surgical, medical, obstetric, radiology, oncology and endoscopy treatments/procedures requiring general/regional anaesthesia, or intravenous sedation
- invasive procedures or treatment where there are known significant risks or risk of complications (i.e. procedural risks)
- sterilisation of a minor or a represented person (special circumstances apply)
- the application of electroconvulsive therapy (special circumstances apply; refer to section 4.2.2 of this Consent Policy)
- administration of medications with known high risk complications or new unusual medications which may have risks
- drugs administered under the Special Access Scheme
- participation in clinical trials and medical research.⁵

While no treatment may be performed without the consent of the patient or a substitute decision-maker, the law does not generally require consent to be given in writing.⁵
Where the Consent Policy requirements summarised above do not apply, treatment may be given as long as:

- it is quite clear to the health professional that the patient consents and
- none of the specific requirements set out in this Consent Policy apply (refer to section 4).

While a consent form is merely evidence of consent, its absence could lead to the conclusion that the procedure has not been discussed with the patient or that the patient has not given his/her informed consent.

For this reason, where the patient is conscious and able to give written consent, it is always preferable that consent be obtained in writing. Furthermore, if consent is only obtained verbally there is a risk for ambiguity around what was said and agreed to.

Therefore, it is essential that the consent process and the outcome are always documented in the patient’s health care record (refer to sections 5 and 9 of this Consent Policy).

The use of the recommended consent forms (copies at Appendices 1 to 6) will:

- assist health professionals to provide adequate and appropriate information to patients under their care during the consent process
- help to ensure that the consent process is carried out in line with legal requirements and expectations.

It is the responsibility of all WA Health facilities to ensure that a patient’s health care record is accurate and kept up to date.
4. When do different arrangements apply in obtaining Consent

Requirements for obtaining consent prior to the commencement of treatment will vary depending on the circumstances. The following situations require different arrangements:

- emergency treatment that is required to save a patient’s life or prevent serious harm (refer to section 4.1 of this Consent Policy)
- treatment provided under the Mental Health Act 1996 (refer to section 4.2 of this Consent Policy)
- treatment is provided, or not provided, under the Guardianship and Administration Act 1990 (refer to section 4.3 of this Consent Policy)
- the patient has made a common law directive refusing specific treatment (refer to section 4.4 of this Consent Policy)
- a minor requires treatment (refer to section 4.5 of this Consent Policy)
- treatment is prohibited by law or is prohibited unless certain requirements are met (refer to section 4.6 of this Consent Policy)
- the procedure involved requires a specific process (refer to section 4.7 of this Consent Policy).

Note: This Consent Policy does not deal with consent for use and transmission of confidential information, such as digital images taken as part of a surgical procedure. Refer to Operational Circular OP 2050/06 ‘Patient confidentiality and divulging patient information to third parties’ for further information.

4.1 Treatment in an emergency

A ‘medical emergency’ is defined as a situation where urgent treatment is necessary to avert a serious and imminent threat to the patient’s life, or physical or mental health.

In the case of a medical emergency the requirements to obtain consent differ from the process set out in section 3 of this Policy.

In a medical emergency where a patient is competent there is a requirement to address the consent process (refer to section 2 of this Consent Policy) within the time constraints of necessity and the patient’s best interest. Even though in this circumstance consent is implied by the patient’s presentation and a formal consent form is not required, the medical emergency and communication with the patient must be clearly documented in the patient record.

The situation is different in a medical emergency where a patient is incompetent and thus not able to consent to the required treatment at the time because of their clinical condition. In this circumstance, treatment that is immediately necessary to save the patient’s life or prevent a serious deterioration in their condition can be provided without consent.
This applies only to a person who:

- is unable to give consent
- does not have an over-riding Advance Health Directive or common law directive that is known and immediately available
- does not have a guardian or enduring guardian with the authority to make treatment decisions and who is immediately available, and
- does not have a substitute decision maker who is immediately available.

The circumstances that constitute the medical emergency and the patient’s inability to consent must be clearly documented in the patient’s health care record.

If and when a patient becomes competent they should be informed of the treatment/procedure that has been performed and the reasons for providing it.

4.2 Provision of treatment under the Mental Health Act 1996

Part 5 of the Mental Health Act 1996 contains specific provisions covering the treatment of patients and consent requirements. Division 2 (sections 95-98 inclusive) deals with informed consent to treatment when the provisions of this Act are involved.

4.2.1 Medical treatment

Under s.110 of the Mental Health Act 1996 an involuntary patient, or a mentally impaired accused person who is in an authorised hospital, may be given medical treatment if this has been approved in writing by the Chief Psychiatrist. However, the Chief Psychiatrist does not have the power to approve medical treatment for an involuntary adult patient if:

- the patient is able to make the decision of him/herself or
- the patient has an Advance Health Directive which covers the required treatment or
- there is a substitute decision-maker available and willing to make the treatment decision (refer to section 4.3 of this Consent Policy).

4.2.2 Psychiatric treatment

Under s.109 of the Mental Health Act 1996 an involuntary patient or a mentally impaired accused person, who is in an authorised hospital, may be given psychiatric treatment without consent.

Specific additional requirements apply to deep sleep therapy, insulin coma or sub-coma therapy, psychosurgery or electroconvulsive therapy (ECT). For further details on these provisions, health professionals should refer to Appendix 7D of this Consent Policy which includes the relevant sections of the on the Mental Health Act 1996.

A consent form for ECT has been endorsed by the Chief Psychiatrist, Department of Health (Appendix 5 Form E).
4.2.3 Emergency psychiatric treatment

Sections 113-114 of the *Mental Health Act 1996*¹ allow for emergency psychiatric treatment (but not including psychosurgery) to be provided to a patient without any consent or approval in order to:

- a) save the person’s life or
- b) prevent the person from behaving in a way that can be expected to result in serious physical harm to the person or any other person.

When emergency psychiatric treatment is provided to a patient, as outlined above, a health professional must ensure that the documentation and reporting requirements set out in s.115 of the *Mental Health Act 1996* are fulfilled.

Please refer to Operational Directive OD 0244/09⁹ or contact the Office of the Chief Psychiatrist for specific information on consent for emergency psychiatric treatment.

Mental health guidelines and further information about the *Mental Health Act 1996* can also be obtained from the Office of the Chief Psychiatrist (refer to contact details at section 12 of this Consent Policy.

4.3 Adult patients unable to make reasonable judgments about treatment decisions - Guardianship and Administration Act 1990⁴

*The Guardianship and Administration Act 1990*⁴ applies to treatment decisions when a patient 18 years or over is not able to make reasonable judgments about proposed treatment. Relevant sections of this Act are at Appendix 7C.

Under section 3 of this Act, a “treatment decision” means a decision to consent, or refuse consent, to the commencement or continuation of any treatment of a person.

This definition of treatment includes “life sustaining measure” and “palliative care”. These terms are also defined in section 3 of the Act (refer to section 11 of this Consent Policy and Appendix 7C).

An adult with full legal capacity can make decisions about the treatment they wish to receive, or not receive at a time in the future when they may not have the legal capacity to make such decisions. Part 9B of this Act provides for a person to make these decisions in an Advance Health Directive (AHD).

An Enduring Power of Guardianship (EPG) allows adults with full legal capacity to appoint another person or persons, (an Enduring Guardian), to make a range of personal, lifestyle and treatment decisions, on their behalf.

An AHD and an EPG only come into effect when a person is unable to make reasonable judgments about proposed treatment, or in the case of an EPG, is unable to make other personal and lifestyle decisions covered by the document.
The Act also allows for the appointment of a Guardian who can be given the power to make a treatment decision on behalf of a patient who is unable to make the decision him or herself. Guardians are appointed by the State Administrative Tribunal on application by a person with an interest in the matter.

The Act (s.110ZJ) sets out the order of priority for substitute decision-makers empowered to make treatment decisions for a patient who is unable to make reasonable judgments about his or her proposed treatment. The circumstances in which substitute decision-makers may make such decisions on behalf of the patient are set out in section 110ZD.

In this Consent Policy the hierarchy of treatment decision-makers is termed the treatment hierarchy (refer to Figure 1 at 4.3.2(iii) of this Consent Policy).

A treatment decision contained in an AHD cannot be overridden by an Enduring Guardian, a Guardian or any other substitute decision-maker.

Furthermore, under s.110ZH of this Part, an advance health directive includes a directive given by a person under the common law containing treatment decisions in respect of the person’s future treatment (refer to section 4.4 of this Consent Policy).

When an adult patient is incapable of making reasonable judgments about his/her treatment the health professional must:

- ascertain whether the patient has previously made an AHD either under Part 9B of this Act or an advance health directive under the common law and if so sight that document and/or
- determine the identity of the appropriate substitute decision-maker and, where an EPG is in place or the patient has a legally appointed Guardian, sight a copy of the EPG document or the Guardianship Order made by the State Administrative Tribunal.

### 4.3.1 Advance Health Directives (AHDs)

Under s.110P of the Guardianship and Administration Act 1990⁴ a person who is at least 18 years of age and who has full legal capacity may make an Advance Health Directive (AHD). The AHD may contain decisions by that person to either consent, or refuse consent, to treatment.

An AHD:

- is the patient’s own consent
- takes precedence over a treatment decision made by a substitute decision-maker
- cannot be overridden by a treatment decision made by a substitute decision-maker (refer to section 4.3.2 of this Consent Policy).

The treatment decisions contained in an AHD will come into effect only if or when the patient is unable to make reasonable judgments about a treatment decision at the time that the treatment decision is required (Part 9D of the Act: Treatment decisions in relation to persons under legal incapacity).
In these circumstances and subject to some limitations, the health professional must provide, or withhold, treatment in accordance with that patient’s wishes as specified in the AHD, if:

- the AHD has been properly executed, and
- the treatment decision covers the treatment proposed.

When sighting the AHD document, the health professional should determine whether or not it covers the proposed treatment.

A person may adapt the AHD form so that it may look slightly different in presentation from the form prescribed in the legislation. However the AHD is valid provided that it is “substantially in the form” prescribed in Schedule 2 of the Guardianship and Administration Regulations 2005.10

Health professionals should consult with any potential substitute decision-maker (refer to section 4.3.2 of this Consent Policy) if they have questions or concerns about the AHD or a treatment decision contained within an AHD. However the substitute decision-maker cannot make the treatment decision while an AHD is in operation.

Legal advice may be required or the matter may need to be referred to the State Administrative Tribunal if:

- the situation has changed since the patient made the AHD, and/or
- the circumstances could not have been foreseen by the patient when he or she made their AHD.

For example a person may have made a treatment decision in anticipation of the progression of a terminal illness but a new treatment for the condition has become available since the AHD was made.

In such situations health professionals should seek legal advice tailored to the specific circumstances of the case. A list of appropriate contacts is provided at section 12 of this Consent Policy.

4.3.2 Treatment decisions by substitute decision-makers

Under the provisions of Part 9D of the Guardianship and Administration Act 19904, a treatment decision can be made for an adult patient by a substitute decision-maker where that patient:

- is unable to make reasonable judgments about a treatment decision at the time that a decision is required
- has not made an advance health directive which applies to the treatment.

A substitute decision-maker may be:

- a person appointed by the patient when he or she had full legal capacity (an Enduring Guardian)
- a person appointed by the State Administrative Tribunal (a Guardian) or
- a relative or person otherwise involved in the patient’s life.
The treatment hierarchy (refer to Figure 1 at section 4.3.2(iii) of this Consent Policy) identifies:

- the criteria for each substitute decision-maker
- the order in which each one should be consulted about a treatment decision.

A treatment decision made by a substitute decision-maker on behalf of a patient has the same effect as if the decision had been made by the patient him or herself.

Where a substitute decision-maker is not willing or available to make the treatment decision, the health professional can move down the treatment hierarchy list until someone who meets the criteria to make the decision is identified.

### 4.3.2(i) Enduring Guardian

A person may make an Enduring Power of Guardianship (EPG) to appoint one or more persons to be their Enduring Guardian if he/she:

- is at least 18 years of age and
- has full legal capacity.

The EPG must be “substantially in the form” prescribed by the legislation in Schedule 1 of the *Guardianship and Administration Regulations 2005*.10

Where a patient is unable to make reasonable judgments about a treatment decision and an AHD is not in operation, an Enduring Guardian is the first substitute decision-maker who should be asked to make the treatment decision.

The authority of an Enduring Guardian will be determined by the content of the EPG which may either include or exclude the authority to make treatment decisions. Health professionals should always ask to sight the EPG document. They should also check to determine whether the Enduring Guardian has the power to make treatment decisions on behalf of the patient.

If an Enduring Guardian has been appointed under clause 4A of the EPG form, he or she will have authority to perform all functions of an Enduring Guardian, including making treatment decisions.

However if the Enduring Guardian has been appointed under clause 4B of the EPG form, he or she will have limited functions and the health professional must ensure that the patient has included authority for the Enduring Guardian under item (d) i.e. to:

> Consent, or refuse consent, on my behalf to any medical, surgical or dental treatment or other health care (including life threatening measures such as assisted ventilation and cardiopulmonary resuscitation). Schedule 1 4B10

Where more than one Enduring Guardian has been appointed, they must make all decisions, including treatment decisions, jointly and unanimously and must act in the best interests of the patient they represent.
Enduring Guardians must also follow the directions contained in the EPG about how they are to perform their functions. In addition to having the authority to make a treatment decision, an Enduring Guardian must be willing and available to do so.

4.3.2(ii) Guardian

Under s.43 of the Guardianship and Administration Act 1990 a Guardian is a person appointed by the State Administrative Tribunal when it is satisfied that the person named in the application for a Guardianship order is:
- at least 18 years of age
- unable to make reasonable judgments about matters relating to his/her person, and
- in need of a Guardian.

Where a patient is unable to make reasonable judgments about a treatment decision and an AHD is not in operation, a Guardian is the second substitute decision-maker who should be asked to make the treatment decision (after the Enduring Guardian, if one has been appointed).

The authority of a Guardian will be determined by the content of the order made by the State Administrative Tribunal, which may either include or exclude the authority to make treatment decisions. Health professionals should always ask to sight a copy of the State Administrative Tribunal’s order. They should also check to determine whether the order allows the Guardian to make treatment decisions on behalf of the patient.

If the State Administrative Tribunal has appointed the Public Advocate as Guardian and has given the Public Advocate the authority to make treatment decisions, the responsible health professional must contact the Office of the Public Advocate in order to obtain a treatment decision.

Where more than one Guardian has been appointed, they must make all decisions, including treatment decisions, jointly and unanimously and must act in the best interests of the patient.

4.3.2(iii) Other substitute decision-makers

The treatment hierarchy identifies the criteria for each substitute decision-maker and the order in which each should be consulted about a treatment decision.

Health professionals should consult the treatment hierarchy where a patient:
- is unable to make reasonable judgments about a treatment decision
- does not have an applicable AHD
- does not have an Enduring Guardian or Guardian
  - with the authority to make the treatment decision
  - who is reasonably available and willing to make the treatment decision
The treatment decision should be made by the first person in the treatment hierarchy who is:
- of full legal capacity and
- reasonably available and
- willing to make the treatment decision.

Where there is more than one person within a category, who meets the criteria for making the treatment decision, the decision may be made by any one of those persons. Age is not a factor in determining which person is approached, for example the eldest child should not be automatically selected.

Section 110ZD of the Act states that the substitute decision-maker:
- must act according to their opinion of the best interests of the patient
- cannot consent to the sterilisation of a patient. (This procedure can only be performed with the consent of the State Administrative Tribunal. Refer to Appendix 7C).

If no one in the treatment hierarchy is available and willing to make the treatment decision, an application should be made to the State Administrative Tribunal to make an order under s.43 of the Act for the appointment of a Guardian with the authority to make treatment decisions on behalf of the patient.

Where the treatment is planned and/or routine medical, surgical or dental treatment or other health care, the treatment decision must be made in accordance with the treatment hierarchy below.
Figure 1: Treatment Hierarchy

Relevant treatment decisions contained in an AHD must be followed unless:
• there is doubt about the validity or operation of the AHD.

First person on this list who is:
• authorised to make the treatment decision (by the Enduring Power of Guardianship or by the State Administrative Tribunal)
• of full legal capacity and
• reasonably available and
• willing to make the treatment decision.

First person on this list who is:
• of full legal capacity and
• reasonably available and
• willing to make the treatment decision and
• at least 18 years of age.

* Has frequent contact with the patient of a personal nature and takes a genuine interest in the patient’s welfare.
** Includes a person who receives a carer payment.
4.3.3 Urgent treatment

Section 110ZH of the *Guardianship and Administration Act 1990* defines urgent treatment as treatment urgently needed by a patient:

(a) to save the patient’s life or
(b) to prevent serious damage to the patient’s health or
(c) to prevent the patient from suffering or continuing to suffer significant pain or distress.

This definition should be read in conjunction with the definition of treatment. Health professionals should note that life sustaining measures and palliative care are now included in this definition of treatment (refer to section 4.3 of this Consent Policy).

Under s.110ZI (1) and (2) of this Act, a health professional may provide urgent treatment if:

- a patient needs urgent treatment (as defined above) and
- the patient is unable to make reasonable judgments in respect of the treatment and
- it is not practicable for the health professional who proposes to provide the treatment to determine whether or not the patient has made an AHD or a common law directive – (refer to section 4.4 of this Consent Policy) that is inconsistent with providing the treatment and
- it is not practicable for the health professional to obtain a treatment decision on behalf of the patient from a substitute decision-maker.

Section 110ZIA, of the Act sets out specific provisions covering situations where the health professional suspects a person has attempted to commit suicide and:

- needs urgent treatment as a consequence and
- is unable to make reasonable decisions in respect of the treatment.

In these circumstances, the health professional may provide the treatment even if:

- the patient has made an AHD inconsistent with the provision of such treatment or
- a substitute decision-maker under sections 110ZD and 110ZJ of the Act has made a different treatment decision in relation to the patient.

4.4 Common Law Directives

The provisions of the *Guardianship and Administration Act 1990* do not affect the common law with respect to the refusal of consent to treatment.

A decision to refuse treatment can be oral or in writing, and can be made at the time that the decision is required or in advance (an anticipatory refusal of consent). The patient’s anticipatory refusal of consent must be respected by health professionals even if the patient’s death is likely or certain to occur as a result.
One common term for a written anticipatory refusal of consent is a “living will”. While an AHD is a formal document under the Guardianship and Administration Act 1990 (refer to section 4.3.1 of this Consent Policy) it is possible for patients to make a “living will” and for this to be valid and legally binding under the common law.

To be valid under the common law, an anticipatory refusal of consent must meet the following criteria. It must:

- not be ambiguous or uncertain
- extend to the particular situation in question
- not have been affected by undue influence
- not be based on incorrect information or an incorrect assumption.

In addition, the patient must have been competent at law at the time that the anticipatory refusal was made.

Legal advice should be sought if the:

- health professional has any doubts about the validity of an anticipatory refusal or
- patient has made both an anticipatory refusal and an AHD under the Guardianship and Administration Act 1990 and the two are inconsistent with each other.

In such situations health professionals should seek legal advice tailored to the specific circumstances of the case. A list of appropriate contacts is provided at section 12 of this Consent Policy.

4.5 Treatment of a minor

4.5.1 Emergencies

The policy regarding obtaining consent to treatment in an emergency is set out in section 4.1 of this Consent Policy. It applies equally to minors.

Thus in the case of an emergency it may not be necessary to obtain parental or other consent for treatment that is necessary to avert a serious and imminent threat to the person’s life or physical or mental health.

4.5.2 Parental consent

In the case of children who are not capable of consenting on their own behalf, the law recognises the right of the children’s parents to consent on behalf of a particular child.

However, the power of parents to consent, or withhold consent, to treatment is limited by the overriding criterion that they can only validly consent to treatment which is in the ‘child’s best interests’.

Furthermore the power of parents to withhold consent does not equate to them having the power to issue orders that treatment must not go ahead. Refer to Appendix 7B of this Consent Policy for the relevant extracts from the Commonwealth Family Law Act 1975.\(^\text{11}\)
Under this Act responsibility for any children who are under 18 years of age:

- rests with parents
- is not affected by changes to relationships (for example, if the parents separate, divorce or remarry)
- may be varied by a court order where family relationships break down and result in actions such as separation and divorce.

4.5.3 Exemptions to obtaining Parental Consent

4.5.3(i) Court Orders

The process of obtaining consent for the treatment of a minor must be consistent with the terms of any court order.

The consent of only one parent is required for a valid consent for a minor to undergo medical treatment. If there is a conflict between two persons with parental responsibility over consent to treatment for a child, attempts should be made to resolve the disagreement. Alternatively, it may be necessary to seek a court order.

Court authorisation for medical treatment of a minor is also required when:

- both the parents and the minor lack the capacity to consent to medical treatment in a non-emergency situation or
- the parents refuse consent for a necessary procedure.

Such authorisation can be obtained by applying to the Supreme Court in its *parens patriae* jurisdiction.

4.5.3(ii) Protection Orders

Under the *Children and Community Services Act 2004*:

- Responsibility for children placed in, or taken into, provisional protection and care, or subject to a negotiated placement agreement, generally remains with the parents.
- Protection orders can vary parental responsibility depending on the type of protection order made.
- The Director General of the Department for Child Protection has statutory authority to make decisions on behalf of such children in specific circumstances (sections 29 and 30 of this Act).

4.5.3(iii) Mature minor (competency of child to consent to medical treatment)

Where a child is a mature minor and able to make a treatment decision, the consent of the child’s parent is not necessary.

The law in Australia considers that a mature minor is a person under the age of 18 years of age who is, by reason of their maturity, capable of giving (or refusing) effective consent to a medical procedure. He or she should fully understand:
the advice being given
the nature of the proposed treatment
the implications and consequences of that treatment.\textsuperscript{5,13}

In determining whether a child is capable of providing consent, health professionals should consider the:

- age and maturity of the child
- child’s ability to understand fully the medical advice being given
- nature, consequences and implications of the proposed treatment and their capacity to understand them
- potential risks to health
- emotional impact on the child of either accepting or rejecting the advised treatment.

Even if a child is a mature minor, and thus able to make a treatment decision for his- or herself, a court order may override that treatment decision if it is not in the child’s best interests (refer to Appendix 7B).

The best interests of a child encompasses more than what is in the best interests of the child’s health. It may be that it is not in the best interests of a child to receive treatment that their parents do not consent to, even if it is the best treatment option.

4.5.3(iv) Statutory provisions governing abortion

Section 334(8) – (11) inclusive of the \textit{Health Act 1911}\textsuperscript{14} set out the statutory provisions applicable to women who are dependent minors (refer to Appendix 7 E of this Consent Policy).

4.5.3(v) Statutory provisions in the \textit{Human Tissue and Transplant act 1982}

The provisions in s.19-21 of the \textit{Human Tissue and Transplant Act 1982}\textsuperscript{15} cover the removal of human tissue and administration of a blood transfusion to a child in the absence of parental consent (refer to Appendix 7F of this Consent Policy).

Where necessary, health professionals should seek legal advice tailored to the specific circumstances of the case. A list of appropriate contacts is provided at section 12 of this Consent Policy.

4.6 Treatment which is prohibited by law or which is prohibited unless certain requirements are met

Forms of treatment prohibited by law include:

- female genital mutilation (s.306 Criminal Code)\textsuperscript{16}
- non-regenerative tissue removal from a child for the purpose of transplantation (s.12 \textit{Human Tissue and Transplant Act 1982})\textsuperscript{15}
- deep sleep therapy, insulin coma or sub-coma therapy (s.99 \textit{Mental Health Act 1996}).
Forms of treatment prohibited by law unless certain requirements are met include:
- abortion (s.199 *Criminal Code*)\(^{16}\)
- regenerative tissue removal from a child for the purpose of transplantation (s.13 *Human Tissue and Transplant Act 1982*)\(^{15}\)
- removal of blood from a child (s.19 *Human Tissue and Transplant Act 1982*)\(^{15}\)
- psychosurgery (s.101 *Mental Health Act 1996*)\(^7\)
- electroconvulsive therapy (s.104 and s.107 *Mental Health Act 1996*)\(^7\)
- sterilisation of a represented person (s.57 *Guardianship and Administration Act 1990*).\(^4\)

At common law it is not lawful to sterilise any incapable person without the consent of the court acting in its *parens patriae* jurisdiction, even if that person does not have a guardian and no application for guardianship has been made unless the sterilisation is incidental to other medical treatment to treat an illness or cure an abnormality (such as treating a cancer of the reproductive system).

### 4.7 Other Procedures where the usual process for obtaining consent may vary

#### 4.7.1 Anaesthesia

The patient should be given:
- information about anaesthesia in advance
- an opportunity to discuss anaesthesia with the anaesthetist at the pre-operative assessment.

If a general, regional or local anaesthetic or intravenous sedation is to be administered to a patient as part of the patient’s planned treatment the patient must be informed about:
- any material risks associated with the anaesthesia and
- the advantages and disadvantages of any available alternative treatments.

At the anaesthetic consultation, (pre-admission clinic) the anaesthetist must complete a detailed anaesthetic consent form for signature by the patient (refer to Appendix D Form D).

Where a patient is referred to an anaesthetist for a separate anaesthetic consultation, it is that anaesthetist’s responsibility to:
- inform the patient of the risks associated with alternative types of anaesthesia (e.g. regional, general or epidural)
- obtain the relevant consent from the patient.

All documentation must be recorded either:
- in the anaesthetic record
- in the patient’s health care record
- OR
- on an appropriate anaesthetic consent form (see Appendix 4 Form D).
This documentation must include a written record of:
- the patient’s consent (including a copy of the consent form signed by the patient)
- any information supplied
- any relevant discussion with the patient.

### 4.7.2 Open-access procedures

The nature of open-access procedures such as endoscopy, interventional or radiological procedures may preclude the health professional from discussing the benefits, risks and likely outcomes of procedures with the patient on the day of the procedure.

Patients who attend open-access endoscopy units should therefore be provided with appropriate information about the risks of the procedure they are to undergo before they make a booking to have that procedure performed.\(^{17}\)

Medical practitioners who refer patients (most commonly general practitioners) to an open-access endoscopy centre have a duty of care, at the time of referral, to provide information about the rare but possible complications of the procedure, including the risks associated with anaesthesia.

WA Health facilities offering open-access endoscopy or other such procedures must ensure that:
- nursing staff in the pre-admission clinic are aware of patients who are booked for an open-access endoscopy
- require sedation or anaesthesia from a specialist anaesthetist
- any endoscopist or anaesthetist who refers patients to the facility has informed the patient of the nature of the proposed treatment
- made an appropriate disclosure of any material risks
- the patient’s consent has been obtained for the proposed procedure and documented in the patient’s health care record.\(^{17}\)

### 4.7.3 Obstetric procedures

Consent for obstetric procedures should be obtained in accordance with the requirements set out in section 3 of this Consent Policy.

However the consent to treatment process outlined in section 4.1 of this Consent Policy should be followed:
- where a blood transfusion is needed
- in the case of an obstetric emergency such as an emergency caesarean section
- where other additional treatment (e.g. an epidural) is given during the course of labour.

Hospitals/health services should ensure that the patient is prepared during ante-natal consultations/classes and advised of possible procedures and treatments.
4.7.4 Blood products

Any health professional who is seeking consent for a blood transfusion must:
- advise the patient of the associated risks
- record discussion with the patient of the risks of any adverse outcomes in the patient’s health care record.\(^{18}\)

Wherever possible, the health professional should also provide the patient with appropriate written information. Useful information for patients may be contained in resources developed by the following bodies:
- Australian and New Zealand Society of Blood Transfusion\(^{18}\)
- National Health and Medical Research Council (NHMRC)\(^{19}\)
- Australian Red Cross Blood Service.\(^{20}\)

Valid consent for blood transfusions or the administration of blood products during surgery can be documented on a Consent to Treatment form. However, where urgent treatment is required in the case of a medical emergency and the patient is not able to consent to the blood transfusion at the time, consent is implied (see sections 4.1 and 9.2.1 of this Consent Policy).

Health professionals should refer to the *Human and Tissue and Transplant Act 1982* (s.19-21)\(^{15}\) in Appendix 7F for the legal situation that applies regarding medical practitioners performing a blood transfusion on a child (under 18 years) without consent.
5. How Should Consent be Sought and Obtained?

To secure valid consent, a health professional has two distinct obligations. These are to:

1. Inform the patient (or in some of the circumstances covered in section 4 of this Consent Policy –the substitute decision-maker) of the nature of the proposed treatment and disclose any material risks involved.
2. Document in the patient’s health care record the process by which consent has been sought.

5.1. What are the requirements for valid consent?

Irrespective of whether or not written consent is obtained, a patient’s consent is only valid if the patient has:

- the capacity to consent
- received sufficient information to make the decision
- been given sufficient time to absorb and consider the information given
- not been pressured (coerced) into making a decision.

An individual has the required capacity to provide or refuse consent if he or she can:

- understand and retain relevant information
- manipulate the relevant information rationally
- reflect and make a judgment based on personal values and the situation
- freely communicate a decision
- understand the implications refusing treatment.

Examples of patients unable to give consent may include persons:

- sedated or temporarily unconscious
- with an altered mental state, e.g. through medication
- currently affected by a mental illness or persons with an intellectual disability
- suffering from Alzheimer’s disease or other forms of dementia.

Arrangements for obtaining treatment decision from substitute decision-makers for patients who are unable to give consent are discussed in section 4.3.2 of this Consent Policy.

5.2 What information should be given to a patient?

The objective of providing information should be to help the patient understand his/her condition and the available options for treatment.

The information must be given in terms, and in a manner, that the patient can comprehend.

When a substitute decision-maker is involved, he or she must be given the same information as would have been given to the patient if that person had had the capacity to make the treatment decision.
As a guide it is recommended that risks should be disclosed and discussed where:
- the chance of an adverse outcome is greater than one case in every thousand (1:1000)\(^2\)
- the risks are likely to be significant to a specific patient.

In determining and discussing risks, the health professional needs to:
- communicate clearly and effectively
- have a good understanding of the patient’s objectives, beliefs and attitudes.

The NHMRC Guidelines for Medical Practitioners\(^2\) set out the minimum level of information that should be provided to patients. Under these guidelines, the information provided should include:
- an explanation of the patient’s condition and diagnosis
- any degree of uncertainty in the diagnosis or prognosis
- the nature of the proposed treatment, including the time required for the treatment, the likely recovery period and the likely time that the patient will be unable to work
- the expected benefits of the treatment
- the potential risks involved in the treatment including
  - any short or long term side effects of the treatment
  - any significant long term physical, emotional, mental, social, sexual or other risks
  - the risk that no benefit will be achieved
  - the risk that the condition will deteriorate after the treatment and/or procedure
- the likely outcomes of the treatment, including whether the procedure is irreversible
- outcomes which are inevitable if the treatment is performed, such as pain, altered bowel function after a cholecystectomy, removal of the umbilicus after repair of an umbilical hernia, or retrograde ejaculation after a prostatectomy
- the likely consequences of not
  - choosing the proposed diagnostic procedure or treatment
  - having any procedure or treatment at all
- alternative options for investigation, diagnosis and treatment and why these other procedures are not recommended
- any costs involved in the treatment
- any follow-up treatment or care which may be required.

Health professionals must also make it clear that they can never guarantee the results of treatment.

Informed financial consent must be obtained separately for any additional expenses that may be incurred as a result of the treatment, including any ‘out of pocket’ expenses.

The patient must also be advised:
- of the name of the health professional primarily responsible for his or her care
- whether or not that person will be performing the procedure
- whether health professionals-in-training will be participating in the treatment.
The names of the health professionals performing the procedure and/or participating in the treatment must be recorded on the consent form that the patient signs.

5.2.1 **How should a patient be informed about material risks?**

Informing a patient of the risks associated with treatment is a very important part of the consent process. Any information provided to a patient must include:

- the general and specific risks of the treatment concerned
- disclosure and explanation of the material risks, if any, of the specific treatment.

The Department of Health strongly supports the guidance issued by the NHMRC on the provision of information to patients.\(^ {24} \) The NHMRC’s advice for medical practitioners\(^ {25} \) state that the factors to be considered when determining how much information to give a patient about the risks of a proposed procedure include:

- the seriousness of the patient’s condition
- the nature of the intervention
  - for example, complex interventions require more information, as do interventions where the patient has no illness
- the likelihood of harm and the degree of possible harm
- the questions the patient asks
- the patient’s temperament, attitude and level of understanding
- current accepted medical practice.

Discussion with the patient of any concerns they may have:

- may occur at the initial meeting between the health professional and the patient,
  at a subsequent meeting
- should occur prior to the commencement of treatment
- should involve senior member of the medical team, preferably the health professional who will perform the procedure.

Where a face-to-face meeting is not possible before the commencement of an open-access procedure or other treatment is not possible (refer to section 4.7.2 of this Consent Policy) other means, such as a telephone contact, may be used.

While a health professional may follow usual professional practice in giving information in a particular situation, this is not conclusive evidence that full information has been provided.

Furthermore it will be important for the health professional to ensure that all the circumstances that relate to a particular patient are taken into account when the information is provided.

The health professional must record in the patient’s health care record:

- all essential and key points of the discussion, including questions raised by the patient and responses provided
- a list of any material risks discussed with the patient.
The accurate recording and documenting of the consent process will be facilitated by use of the recommended generic consent forms (Appendices 1-6) developed by the Department of Health.

5.2.2 How should information be provided to a patient from a culturally and/or linguistically diverse background or who has special needs?

Health professionals should be aware that a patient from a culturally and/or linguistically diverse background (CALD) or a patient, who has a physical impairment, or mental impairment, may need additional support to provide valid consent to treatment.

Where patients are illiterate or vision or hearing impaired, health professionals must:
- employ appropriate communication methods OR
- enlist support from a person who can assist in communicating with the patient.

All actions taken must be documented in the patient’s health care record.

Where a patient is identified as having special needs or language requirements, the health professional should engage the services of a Professional Interpreter.24

5.2.2(i) How should an interpreter be engaged?

Where a Professional Interpreter is required, health professionals should refer to the Office of Multicultural Interests’ *The WA Language Services Policy* (2008)26 definition of “competent interpreters and translators”. Refer to definition at section 11 of this Consent Policy.

Where possible interpreters should be given the opportunity to review relevant documentation about the consent process and prepare for the interpretation task before meetings between the health professional and the patient occur.

An interpreter who has been present should indicate on the consent form that he or she has interpreted the discussion between the health professional and the patient to the best of his or her abilities. An interpreter who is not confident of his or her competence to interpret a discussion between a health professional and a patient, should advise the health professional accordingly and decline, or withdraw from, the interpreting assignment.

If an interpreter expresses concerns about his or her performance that is sufficiently serious for him/her to withdraw from the assignment, the health professional should obtain the services of an alternative interpreter. If the health professional asked the original interpreter to continue in the role, this request should be documented together with the interpreter’s notation on the consent form.
5.2.2(ii) What is the role of the interpreter?

The *Western Australian Language Services Policy 2008*\(^{26}\) sets out guidelines which can help health professionals to obtain assistance for patients who require language services.

If an interpreter is required during discussions with a patient, the health professional must:

- convey the essence of any information sheet used and the consent form to the patient, in the presence of the interpreter
- ensure that the patient understands to what he or she is consenting.

The role of the interpreter is solely to convey the information between the health professional and the non-English speaking patient. It is beyond the interpreter’s responsibility to:

- complete forms
- provide other functions, such as,
  - provision of medical advice
  - the clarification of written medical information\(^{27-28}\).

Professional Interpreters should be engaged wherever possible, in preference to other interpreters and/or family members.\(^{29}\)

All attempts should be made to gain access to a Professional Interpreter before the health professional has recourse to a non-accredited interpreter, family, friends or bilingual health workers.

If an interpreter is used during discussions with a patient, health professionals are required to convey to the patient all vital information (including that on the consent form) such as risks, in the presence of an interpreter. This mode of operating should enable the health professional to be confident that the patient understands the nature and effects of the procedure to which he/she is consenting.

5.2.3 Can pre-prepared information be given to patients?

Informing patients of the benefits and risks of the procedure or treatment is a very important part of the consent process.

Where available, health professionals should provide patients with appropriate written or audiovisual information resource materials to supplement their discussion of the benefits and risks of a proposed procedure. However written information brochures or pamphlets must not be used as a substitute for a face-to-face meeting.

When using previously prepared information resources, health professionals must be cognisant that:

- pre-printed information sheets usually refer to the risks facing an “average” patient having the treatment
- many patients (those who are older, chronically ill, have co-morbidities, etc.) will face much higher risks than those shown in the information sheets.
This latter point must be stressed when pre-printed material is used during discussions between health professionals and their patients.

The Department of Health has purchased a suite of Procedure Specific Information Sheets, which are available for use in all WA Health facilities. These can be a useful source of information and can be given to patients. Copies can be downloaded at: http://www.safetyandquality.health.wa.gov.au/home/.

In addition to these Information Sheets, a range of printed material for patients has been developed by several State and Territory Departments of Health and learned colleges to assist health professionals in managing the informed consent process. Resource information may be obtained by contacting the relevant colleges including:

- The Royal Australsian College of Surgeons
- Australian and New Zealand College of Anaesthetists
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

The following websites may also include helpful advice and information for patients:

- Royal Australian and New Zealand College of Radiologists website Inside View: www.ranzcr.edu.au/consumer/index.cfm
- Health Department of WA: Diagnostic Imaging Pathways website: www.imagingpathways.health.wa.gov.au

It is the Department of Health policy that where information resources, developed by individual health professionals or external groups, such as the learned colleges, are used, this material must be endorsed by the hospital/health service executive to ensure that they are:

- up to date
- accurate, clear and concise
- relevant to the patient’s needs.

The Department of Health recommends that hospitals/health services establish a register of patient information resources. Appropriate audit processes should be maintained to ensure that resources used are continually reviewed and updated to meet new changes in clinical practice.

5.2.3(i) Can the old Department of Health procedure-specific consent forms be amended and used as information sheets?

Area Health Services should note that the suite of Procedure Specific Consent Forms (PSCFs), previously developed by the Department of Health in 2002, are no longer updated or supported following the release of this Consent Policy. These PSCFs have been replaced by new Procedure Specific Information Sheets (PSIS) and recommended generic consent forms (see Appendices 1-6).

5.2.4 Can information be withheld from a patient?

It is Department of Health Policy that health professionals should not withhold information from a patient on the grounds that full disclosure would be harmful to the patient’s physical or mental health or welfare.

The withholding of information on such grounds is known as the defence of therapeutic privilege. This doctrine has been applied in Australia, and was specifically endorsed as part of Australian law by the High Court in Rogers v Whitaker (1992) 175 CLR 479. However there has been negligible application of this defence since that endorsement and it would appear it can no longer be used by a health professional as a reason for not complying with the requirements of the consent process. For this reason, information about possible risks should not be withheld from a patient, even where the risk may be seen as minor. At the same time, health professionals should aim to act in accordance with the NHMRC guidelines on the provision of information to patients (refer to section 5.1 of this Consent Policy).

5.2.5 What if the Patient does not want information?

Some patients will state that they do not want to be burdened with a whole lot of information and they would prefer to leave the treatment decision to the health professional. In these circumstances the health professional should encourage the patient to reconsider a wish not to receive information about the treatment proposed. However the patient should not be coerced and if there is a continued reluctance on the patient’s part to receive information the health professional should:

- try and determine why the patient does not want to be informed
- if the patient feels unable to deal with the matter, ensure that the patient understands, at least broadly, what is involved.
6. Who is Responsible for Obtaining Consent?

The health professional that recommends treatment or advises a patient to undergo treatment is responsible for providing sufficient and appropriate information and advice to the patient.

Where a team of health professionals is involved, the responsibility for the consent process lies with the most senior health professional responsible for:
- providing the treatment
- performing the procedure to which the patient is being asked to consent.

6.1 Can another health professional obtain a patient’s consent to treatment?

This Consent Policy recognises that teamwork is a crucial part of the way in which hospitals/health services operate. In some cases, therefore:
- the health professional undertaking the ‘consenting discussion’ may not be the person who will perform the procedure or treatment
- another member of the treating team may be asked to obtain the patient’s consent to treatment.

The name of the health professional responsible for obtaining consent must be documented in the patient’s health care record.

Irrespective of who undertakes the consent process, the health professional performing the treatment, is ultimately responsible for ensuring that consent to treatment has been properly obtained.

In the majority of cases this will be most senior health professional on the treating team.

It is therefore essential that the senior health professional takes reasonable steps to ensure:
- that the patient has been properly informed
- a consent form has been completed and signed before the patient undergoes surgery or treatment.

6.1.1 Can the consent process be delegated to another ‘uninvolved’ health professional or junior health professional?

If a senior health professional delegates the task of obtaining a patient’s consent to treatment to a junior health professional or another ‘uninvolved’ health professional:
- this delegation must be documented in the patient’s health care record
- the senior health professional must ensure that the other health professional is competent to undertake that task.
Any health professional who has been delegated to perform the consent task must be aware that he or she has legal and professional responsibilities to:

- provide all necessary and proper information
- assist the patient in making a decision
- obtain a valid consent to treatment.

An ‘uninvolved’ health professional or junior health professional should therefore refuse to undertake the delegated task if he or she does not consider he or she has sufficient skill or experience to meet these legal and professional responsibilities.

Refusal by a health professional to undertake the consent process on behalf of another person must be:

- documented in the patient’s health care record
- respected by the hospital/health service and senior health professional.

6.1.2 Can nurses and other health professionals be involved in providing information and obtaining consent for procedures that are performed by medical practitioners?

Where this Consent Policy requires the consent process to be documented in writing, the task of informing a patient about the material risks of an operation, procedure or treatment and of obtaining consent cannot be delegated to administrative or nursing staff, other than nurse practitioners or eligible midwives (refer to section 6.1.3 of this Consent Policy).

However, in some cases, a medical practitioner (or nurse practitioner/eligible midwife) may:

- inform the patient of the benefits and material risk of a procedure
- obtain verbal consent
- subsequently ask a hospital staff member to have the patient complete the consent form.

In this situation the staff member is not seeking consent but is simply asking the patient to confirm his or her prior consent.

The medical practitioner or nurse practitioner responsible for obtaining consent must document the nature of his or her discussion in the patient’s health care record.

6.1.3 Can nurse practitioners and eligible midwives obtain consent for the treatment they perform?

Nurse practitioners are registered nurses authorised to work at an advanced level of practice by the national Nursing and Midwifery Board of Australia (replacing the Nursing and Midwives Board of Western Australia). Similarly, eligible midwives have been authorised by that Board to provide, in addition to general midwifery procedures, associated services including the ordering of diagnostic investigations.

Nurse practitioners and eligible midwives have the same obligations as medical practitioners to seek a patient’s consent for the procedure they are performing and not to undertake that procedure in the absence of informed consent.
7. For how long is Consent valid?

In principle, a health professional’s duty to disclose material risk and obtain a patient’s consent for treatment is a continuing obligation. The consent process must occur:

- before the decision is made to proceed with treatment
- as close as is reasonably practicable to the commencement of the treatment process
- preferably prior to admission.

Consent is considered valid until a patient withdraws consent or there is a change in a patient’s circumstances, which may include:

- improvement or deterioration in the patient’s condition
- development of new treatment options since consent was given
- progression of the disease which may have changed the therapeutic goal from “cure” to “palliative care”.

It is a requirement of this Consent Policy that:

- a patient’s clinical condition and consent must be reviewed if his or her consent was obtained more than three months prior to the treatment being performed
- evidence of such a review is documented in the patient’s health care record.

The previously completed form may be revalidated if the patient’s circumstances have not altered, otherwise a new consent form should be completed.

The consent process must be renewed if the period between the date of consent and the date of the procedure being performed exceeds six months.

If a patient consents to a procedure and then subsequently withdraws his or her consent the consent is no longer valid. In this situation the date of withdrawal and any relevant circumstances must be documented in the patient’s health care record.

Patients must be made aware that reconsideration of treatment or withdrawal of treatment is always an option and any changes in the patient’s treatment decision should be documented in the patient’s health care record.

The legal requirements pertaining to Advance Health Directives (AHDs) are covered in section 4.3.1 of this Consent Policy. While tests for determining whether the AHD is still operational include the length of time since it was executed, an AHD continues in operation for an indefinite period and thus constitutes an exception to the Department’s policy regarding the length of time for which a patient’s consent is valid.

Common Law directives (section 4.4 of this Consent Policy) also remain valid for an indefinite period and also constitute an exception to the Department of Health’s policy regarding the length of time for which a patient’s consent is valid.
7.1 Consent for a course of treatment, e.g., chemotherapy

Some treatments, such as chemotherapy, can involve more than one course of treatment. In this situation, a single consent to treatment form is adequate to document consent for the entire course of treatment.

However the consent form must clearly state that consent is given for the entire course of treatment. In such situations it is preferable to outline on the consent form and include in the patient’s health care record appropriate details covering:

- the elements of the course of treatment and any associated material risk
- the alternatives
- the consequences of withdrawal at a future date.
8. **What if a Patient Refuses to Consent to Treatment?**

If a patient who is competent at law refuses to sign a written consent form for non-urgent treatment the health professional should not proceed with treatment until or unless consent has been validly obtained.

Where a patient refuses consent to treatment, the health professional must determine whether the patient’s refusal is related to the:

- requirement to sign the form
- nature of the treatment itself.

In such circumstances the patient’s concern may be alleviated by further explanation of the:

- patient’s condition
- proposed treatment or procedure
- meaning and intent of the consent form.

Interpreting services should be engaged if required. The patient may also be advised to obtain a second opinion from another qualified health professional.

If a patient refuses recommended diagnostic and therapeutic interventions, particularly when the decision involves potentially life-threatening conditions, this refusal should be clearly documented in the patient’s health care record.

The patient should also be encouraged to inform his or her family and any potential substitute decision-maker (see section 4.3.2(iii) of this Consent Policy) of a decision to refuse consent for the recommended treatment.
9. How Should the Consent Process be Documented?

All facilities within WA Health must verify that a health professional has completed the consent process for each patient and has satisfied his or her obligations in obtaining valid consent.

It is the responsibility of the hospital/health service to ensure that a patient’s consent has been obtained by a health professional at each of the following stages:

1. At the pre-admission clinic or at home (where applicable)
2. At the patient’s admission to hospital (where applicable)
3. Prior to the administration of the pre-operative medication
4. Prior to the patient’s transfer to operating theatre, diagnostic unit or medical imaging department.

Evidence that valid consent for the proposed treatment has been obtained from the patient should include documentation in the patient’s health care record or production of a completed consent form.

9.1 What if the patient is admitted from the health professional’s private rooms?

Any health professional who admits a patient to a public hospital from his or her private rooms must comply with the requirements for obtaining a patient’s consent, as outlined in this Consent Policy. This applies irrespective of whether the patient is to be admitted as a public or private patient.

When a patient is admitted to a public hospital, it is the responsibility of the health professional to provide documented evidence that the consent process has been completed. Evidence may include production of a completed consent form or a copy of documentation that is held in the patient’s health care record.

It is recommended that all hospitals and health services provide health professionals with clear directions on procedures for documenting a patient’s consent to treatment prior to his or her admission to hospital. Copies of any relevant consent forms to be used for documenting written consent should also be provided to health professionals for use in their private rooms.

9.2 What if a patient arrives in the operating theatre without valid or documented consent?

If a patient arrives in the operating theatre or treatment room without valid or documented consent, the clinical team must first determine whether the patient requires emergency treatment.
9.2.1 Emergency treatment
The definition of medical emergency and the requirements to obtain consent in these circumstances are set out in section 4.1 of this Consent Policy. They apply equally in an operating theatre situation where urgent treatment is necessary to avert a serious and imminent threat to the patient’s life, or physical health.

In addition to the requirements identified in section 4.1, when a patient arrives in an operating theatre in these circumstances, the Director of Clinical Services and the relevant Nurse Manager should be contacted by the managing surgeon to:
- obtain authority to proceed
- confirm that emergency treatment is necessary and in the patient’s best interest.

A record of authority to proceed should be documented (stating date, time and signature) in the patient’s health care record by the managing surgeon.

If authority to proceed is not obtained the procedure should not go ahead. The incident should be:
- documented in the patient’s health care record
- reported as a clinical incident to the Advanced Incident Management System (AIMS)
- investigated in accordance with the Department of Health’s Clinical Incident Management Policy for WA Health Services using the Advanced Incident Management System
- reviewed by the Director of Clinical Services.

9.2.2 Non-emergency treatment
If a valid consent and signed consent form has not been obtained for a non-emergency treatment prior to arriving at the operating theatre this is a clinical incident. The incident should be:
- documented in the patient’s health care record
- reported as a clinical incident to the Advanced Incident Management System (AIMS)
- investigated in accordance with the Department of Health’s Clinical Incident Management Policy for WA Health Services using the Advanced Incident Management System.

In addition, theatre staff must contact the first available officer, listed below in order of priority, and advise him or her that pre-operative sedation cannot be given and the treatment is unable to proceed without consent.

1. Surgeon
2. Anaesthetist who ordered the pre-operative medication
3. The Director of Clinical Services and Clinical Nurse Manager
9.2.2(i) Competent patients
It is departmental policy that if a patient has not been administered medication that may alter his or her mental state, the treatment should not proceed. If the surgeon or Director of Clinical Services considers that the situation constitutes an emergency, the process outlined in section 4.1 of this Consent Policy should be followed.

9.2.2(d) Incompetent patients
Where a patient has been administered medication that may alter his or her mental state or is otherwise incompetent, the surgeon and anaesthetist must BOTH:

- document in the patient’s health care record their actions and rationale for proceeding with the procedure; and
- sign an Authorisation to Proceed with Surgery on a Patient without a Valid Consent Form (see Appendix 6 Form F).

The Authorisation to Proceed with Surgery on a Patient Without a Valid Consent Form is available from the hospital/health service’s medical records department or from the Office of Safety and Quality in Healthcare website www.safetyandquality.health.wa.gov.au.

9.3 Generic consent to treatment forms
The Consent to Treatment form, stored in a patient’s health care record, represents a record of the minimum amount of information that is acceptable prior to the commencement of treatment or admission to a hospital/health service for treatment.

The presence of a completed consent form does not preclude the fact that an appropriate record of the information provided to a patient and of discussions with the patient (refer to section 3 of this Consent Policy) should also be kept in the patient’s health care record.

The consent forms attached at Appendices 1-6 have been developed for use in the most commonly occurring situations, which are when:

- the patient is an adult or mature minor: Form A Patient Consent to Treatment or Investigation should be completed and retained in the patient’s health care record
- a parent or Guardian is consenting on behalf of a child or minor: Form B Consent for a Minor Requiring Parental/Guardian Approval for Treatment or Investigation should be completed and retained in the patient’s health care record
- an authorised substitute decision-maker is consenting on behalf of the patient who is unable to consent: Form C Adults Unable to Consent to Treatment or Investigation should be completed by the authorised person and retained in the patient’s health care record
- where a patient requires anaesthesia, Form D Patient Consent to Anaesthesia (general or regional) should be completed by the authorised person and retained in the patient’s health care record.
A separate consent form for Electroconvulsive Therapy (ECT) (Form E) has been endorsed by the Chief Psychiatrist, Department of Health for use within WA Health (See Appendix 5).

An additional consent form with respect to Authorisation to Proceed with Surgery on a Patient without a Valid Consent Form is provided at Appendix 6 (Form F).

9.3.1 Development of specialty consent forms

There may be instances, due to local hospital/health service operational policies, where specific consent forms may need to be developed and used for treatment other than previously specified in this policy, for example, for use in:
- experimental treatment
- other procedures that require specific written consent by law.

Hospitals/health services should clearly outline these requirements in local operational policies and make the specific consent forms available where these are required.

Where health professionals or hospitals/health services develop consent forms for specific procedures, hospitals/health services must ensure that they contain the minimum criteria for valid consent that are contained in the recommended generic consent forms provided in Appendices 1-6.
10. Governance Responsibilities of Hospitals in Implementing this Consent to Treatment Policy

The effective and efficient operation of this policy is dependent on the patient’s health care record being updated at the time a decision is made by a patient as to whether or not to consent to treatment. It is also essential that the information entered in the patient’s health care record is both accurate and comprehensive.

Hospitals/health services should, as part of their clinical governance activities, undertake audits of patient health care records to measure compliance with the informed consent process specified in this Consent Policy. The focus of the audit is to verify the use of an appropriate consent form and the recording of discussions and/or dialogue between a health professional and patient in the patient’s health care record.

While the overall goal is to develop a standardised consent process across WA Health, it is equally recognised that there needs to be some flexibility at the hospital/health service level to accommodate local variation in patients and practices.

With the increased mobility of health professionals and frequent use of agency or casual staff it is preferable that all WA public health services develop and maintain standardised policies across their respective hospitals, to minimise potential problems which commonly occur through highly variable protocols.
## 11. Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>A person who is at least 18 years of age.</td>
</tr>
<tr>
<td>Advance Health Directive</td>
<td>A formal document in which a person with full legal capacity makes decisions about their future treatment (Refer to Part 9B of the Guardianship and Administration Act 1990). Under Part 9D of this Act, an advance health directive also includes a directive under common law containing a person’s treatment wishes.</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally and linguistically diverse (persons).</td>
</tr>
<tr>
<td>Capacity</td>
<td>The extent to which a person is able to make reasonable judgments about their treatment and personal welfare. See also full legal capacity.</td>
</tr>
<tr>
<td>Common Law Directive</td>
<td>An oral or written anticipatory refusal of consent made by a person at a time when he/she was competent to make such decisions and which must be respected by a health professional (sometimes called a “Living Will”).</td>
</tr>
<tr>
<td>Competence at Law</td>
<td>The presumption at law that an adult person is able to make decisions unless there is clear evidence or knowledge that they are not. Persons who are competent at law have the right to accept or refuse treatment in most circumstances.</td>
</tr>
<tr>
<td>Competent patient</td>
<td>A patient who is competent at law (see above) and thus able to decide whether or not to agree to treatment.</td>
</tr>
</tbody>
</table>
### Competent Interpreters

Those who adhere to a professional Code of Ethics, observe impartiality and confidentiality principles and perform interpreting and translating tasks accurately and faithfully.26

Competent interpreters must meet at least one of the following criteria:

1. NAATI accredited, which can be achieved by passing a NAATI test; or by successfully completing a course of studies at an Australian institution approved by NAATI or by providing evidence of specialised qualifications in translating and/or interpreting obtained from a recognised training institution outside Australia.
2. Obtained a formal qualification in interpreting or translating from an accredited tertiary institution.

In languages where there is neither NAATI accreditation nor formal training available, for example in some Aboriginal languages and new and emerging migrant languages, interpreters and translators need to meet at least one of the following criteria:

1. NAATI recognised, which requires evidence of English proficiency, two referee reports and completion of a short training course
2. Employed by an appropriately approved external language service provider.

Relevant health service managers must ensure that all interpreters and translators engaged in ‘child-related work’, as defined by the *Working With Children (Criminal Record Checking) Act 2004*, hold a current Working With Children Card before working in WA Health.

### Department of Health

Refers to the administrative arm of WA Health located at Royal St East Perth.

### Emergency Psychiatric Treatment

**Treatment** that can be provided to a patient without any approval or consent in order to (a) save the person’s life, or (b) prevent the person from behaving in a way that can be expected to result in serious physical harm to the person or any other person (see *Mental Health Act 1996* sections 113-114).

### Enduring Guardian

A person appointed under an **Enduring Power of Guardianship** to make personal, lifestyle and **treatment decisions** on behalf of the **adult** person who makes the appointment (see the *Guardianship and Administration Act 1990* Part 9A).
<table>
<thead>
<tr>
<th><strong>Enduring Power of Guardianship</strong></th>
<th>A document in which a person nominates someone (an <strong>Enduring Guardian</strong>) to make personal, lifestyle and <strong>treatment decisions</strong> on their behalf in the event that they lose the <strong>capacity</strong> to do so themselves (see the <strong>Guardianship and Administration Act 1990</strong> Part 9A).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full legal capacity</strong></td>
<td>The <strong>capacity</strong> to make a formal agreement and to understand the implications of statements contained in that agreement.</td>
</tr>
<tr>
<td><strong>Guardian</strong></td>
<td>An <strong>adult</strong> appointed by the <strong>State Administrative Tribunal</strong> to make personal lifestyle and <strong>treatment decisions</strong> on behalf of an adult person who does not have the <strong>capacity</strong> to make such decisions for him/herself and is need of a Guardian (see the <strong>Guardianship and Administration Act 1990</strong> Part 9A).</td>
</tr>
<tr>
<td><strong>Health Professional</strong></td>
<td>Any person who practises a discipline or profession in the health area that involves the application of a body of learning, including a person belonging to a profession specifically defined by legislation. Full definition is available in section 5PA <strong>Civil Liability Act 2002</strong> (see Appendix7 G).</td>
</tr>
<tr>
<td><strong>Incompetent patient</strong></td>
<td>A patient who is not <strong>competent at law</strong> and thus unable to decide whether or not to agree to <strong>treatment</strong>.</td>
</tr>
<tr>
<td><strong>Interpreter</strong></td>
<td>See <strong>competent interpreters and translators</strong></td>
</tr>
<tr>
<td><strong>Life Sustaining Measure</strong></td>
<td>Medical, surgical or nursing <strong>procedure</strong> that replaces a vital bodily function which is incapable of working independently. Includes assisted ventilation and cardiopulmonary resuscitation [see <strong>Guardianship and Administration Act 1990</strong> s.3 (1)]</td>
</tr>
<tr>
<td><strong>Living Will</strong></td>
<td>See <strong>common law directive</strong></td>
</tr>
</tbody>
</table>
| **Material Risk** | “A risk which, in the circumstances of the particular case, a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it, or if the medical practitioner is or should reasonably be aware that a particular patient, if warned of the risk, would be likely to attach significance to it”.

1 |
<p>| <strong>Medical emergency</strong> | A situation where urgent treatment is necessary to avert a serious and imminent threat to the patient’s life, or physical or mental health. |
| <strong>Medical Practitioner</strong> | A <strong>health professional</strong> as defined in s.4 <strong>Medical Practitioners Act 2008</strong>. |
| <strong>Mature Minor</strong> | A minor who fully understands the nature and consequences of the proposed <strong>treatment</strong> procedure and is therefore capable of effective consent or withholding consent. |
| <strong>Minor</strong> | A person under the age of 18 years, i.e. not an <strong>adult</strong>. |</p>
<table>
<thead>
<tr>
<th><strong>Next of kin</strong></th>
<th>See treatment hierarchy of substitute decision-makers.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Palliative Care (GA Act)</strong></td>
<td>A medical, surgical or nursing procedure directed at relieving a person’s pain, discomfort or stress but is not a life sustaining measure [see Guardianship and Administration Act 1990 s.3 (1)].</td>
</tr>
<tr>
<td><strong>Parens Patriae</strong></td>
<td>The inherent jurisdiction of the State to protect human dignity and rights of those who cannot protect themselves.</td>
</tr>
<tr>
<td><strong>Procedural Risk</strong></td>
<td>A professionally recognised risk that a given procedure is likely to induce any of the following: (a) functional impairment; (b) injury; (c) morbidity; (d) death. Patients must consent in writing to treatment which includes a procedural risk.</td>
</tr>
<tr>
<td><strong>Professional Interpreter</strong></td>
<td>See competent interpreters and translators.</td>
</tr>
<tr>
<td><strong>Reasonable judgments</strong></td>
<td>The ability to make decisions about whether or not to consent to treatment.</td>
</tr>
<tr>
<td><strong>State Administrative Tribunal (SAT)</strong></td>
<td>The tribunal established under the State Administrative Tribunal Act 2004 to hear disputes about different types of applications related to civil commercial and personal matters. SAT hears matters covered by the Guardianship and Administration Act 1990.</td>
</tr>
<tr>
<td><strong>Substitute decision-maker</strong></td>
<td>A person who makes a treatment decision on behalf of a patient who is unable to make reasonable judgments for him/herself. It includes a guardian appointed by the State Administrative Tribunal with authority to make decisions and Enduring Guardians where an EPG has given them the authority to make treatment decisions.</td>
</tr>
<tr>
<td><strong>Special Access Scheme (SAS)</strong></td>
<td>A scheme which allows a medical practitioner under certain circumstances, to prescribe drugs not yet approved for the Australian market for treatment of patients with serious medical conditions, with their informed consent. Approval to obtain such drugs is arranged through the Drug Safety Evaluation Branch of the Therapeutic Goods Administration (TGA).</td>
</tr>
<tr>
<td><strong>Therapeutic privilege</strong></td>
<td>The withholding of information by a health professional where there are reasonable grounds for concluding that the patient’s physical or mental health might be seriously harmed by the information.</td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td>Any medical, surgical or dental treatment or other health care, including a life-sustaining measure or palliative care [see Guardianship and Administration Act 1990 s.3 (1)].</td>
</tr>
<tr>
<td><strong>Treatment Decision (GA Act)</strong></td>
<td>A decision to consent or refuse consent to the commencement or continuation of any treatment of the person (see Guardianship and Administration Act 1990).</td>
</tr>
</tbody>
</table>
## Treatment Hierarchy (GA Act)

The consent process which must be followed for patients under legal incapacity who are unable to make **reasonable judgments** about treatment. The hierarchy identifies the criteria for each **substitute decision-maker** and the order in which they should be consulted about a **treatment decision** (see Guardianship and Administration Act 1990 s.110ZD & s.110ZJ).

## Urgent treatment (GA Act)

Treatment urgently needed to save a patient’s life, prevent serious damage to the patient’s health or to prevent the patient from suffering or continuing to suffer significant pain or distress (see Guardianship and Administration Act 1990 s110ZH).

## WA Health

Refers collectively to the public health system of Western Australia including the **Department of Health**, the various metropolitan and country area health services, public hospitals and other public service health agencies.
12. Useful Contacts and Sources of Information

Legal and Legislative Services Directorate of the Department of Health
Tel: (08) 9222 4038

State Solicitor’s Office
For legal advice in the case of teaching hospitals only.
Tel: (08) 9264 1111

Office of the Public Advocate
Level 1, 30 Terrace Road,
EAST PERTH WA 6004
Telephone advice line: 1300 858 455
Fax: (08) 9278 7333
email: opa@justice.wa.gov.au
website: www.publicadvocate.wa.gov.au

Advance Health Directive information
- The Office of the Chief Medical Officer
  Tel: (08) 9222 2072
  Fax: (08) 9222 2130
  email: chiefmedicalofficer@health.wa.gov.au
- Advance Health Directive (ADH) website
- Office of the Chief Psychiatrist for AHDs and mental health

State Administrative Tribunal
Applications to become a guardian are made to the state Administrative Tribunal.
Further information is available via the website below and the Office of the Public Advocate

Department for Child Protection
Tel: (08) 9222 2555
Fax: (08) 9222 2776
After hours Crisis Care: (08) 9223 1111
Country Areas Free Call: 1800199 008
website: www.community.wa.gov.au/DCP/
Learned Colleges

- The Royal Australasian College of Surgeons  
  website: www.surgeons.org/
- Australian and New Zealand College of Anaesthetists  
  website: www.anzca.edu.au/
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists  
  website: www.ranzcog.edu.au/
- Royal Australian and New Zealand College of Radiologists  
  website: www.ranzcr.edu.au/
Appendix 1 - Form A

<table>
<thead>
<tr>
<th>Affix hospital identification here</th>
<th>Surname</th>
<th>UMRN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Consent to Treatment or Investigation</td>
<td>Given names</td>
<td>DOB</td>
</tr>
<tr>
<td>(Page 1 of 2)</td>
<td>Address</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suburb</td>
<td>Postcode</td>
</tr>
</tbody>
</table>

This form is to be completed giving due consideration to the “Consent to Treatment Policy for the Western Australian Health System”

**Declaration of doctor/proceduralist (to be completed by the clinician obtaining consent)**

Tick the boxes or cross out and initial any changes or information not appropriate to the stated procedure

- I have informed the patient of the treatment options available, and the likely outcomes of each treatment option, including known benefits and possible complications.
- I have recommended the treatment/procedures/investigations noted below on this form.
- I have explained the treatment/procedures/investigations, identified below, and what is entailed for the patient.
- I have provided the patient with information specific to the procedure identified. The patient has been asked to read information provided and ask the doctor/proceduralist questions about anything that is unclear. An identifiable copy of the information I have provided to the patient has been kept on the patient’s health care record. Information provided to the patient includes:
  - Open access procedures
    - I have given the patient opportunity to discuss the proposed procedure, benefits and risks, both general and specific and the risk of not having the procedure.
  - Other Procedures
    - I have discussed the proposed procedure, benefits and risks, both general and specific, and the risks of not having the procedure.

**Treatment/procedure/investigation**

List the treatment/procedures/investigations to be performed, noting correct side/correct site

This procedure requires: □ General and/or Regional Anaesthesia □ Local Anaesthesia □ Sedation

An Anaesthetist will explain the risk of general or regional anaesthesia to you.

**Disclosure of material risks**

Material risks or specific risks particular to this patient that have arisen as a result of our discussions are:

**Signature of doctor/proceduralist obtaining consent**

Full name ___________________________ Position/Title ___________________________
Signature ___________________________ Date ___________________________

**Signature of doctor/proceduralist with overall responsibility for treatment (if different)**

Full name ___________________________ Position/Title ___________________________
Signature ___________________________ Date ___________________________
Consent to Treatment Policy for the Western Australian Health System 2011

<table>
<thead>
<tr>
<th>Affix hospital identification here</th>
<th>Surname</th>
<th>UMRN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Consent to Treatment or Investigation (Page 2 of 2)</td>
<td>Given names</td>
<td>DOB</td>
</tr>
<tr>
<td>Address</td>
<td>Suburb</td>
<td>Postcode</td>
</tr>
</tbody>
</table>

**Patient’s declaration**

Please read the information carefully and tick the following to indicate you have understood and agree with the information provided to you. Any specific concerns should be discussed with your doctor or proceduralist performing the procedure prior to signing the consent form.

- The doctor/proceduralist has explained my medical condition and prognosis to me. The doctor/proceduralist also explained the relevant diagnostic treatment options that are available to me and associated risks, including the risks of not having the procedure.
- The risks of the procedure have been explained to me, including the risks that are specific to me and the likely outcomes. I have had an opportunity to discuss and clarify any concerns with the doctor or proceduralist.
- I understand that the result/outcome of the treatment/procedure cannot be guaranteed.
- I understand that if I am treated as a public patient, no guarantee can be provided that a particular doctor/proceduralist will perform the procedure, and that the doctor/proceduralist performing the procedure may be undergoing training.
- I understand that tissue samples and blood removed as part of the procedure or treatment will be used for diagnosis and common pathology practices (which may include audit, training, test development and research), and will be stored or disposed of sensitively by the hospital.
- If a staff member is exposed to my blood, I consent to a sample of blood being collected and tested for infectious diseases. I understand that I will be informed if the sample is tested, and that I will be given the results of the tests.
- I agree for my medical record to be accessed by staff involved in my clinical care and for it to be used for approved quality assurance activities, including clinical audit.
- I understand that if immediate life-threatening events happen during the procedure, I will be treated accordingly.
- I understand that I have the right to change my mind at any time before the procedure is undertaken, including after I have signed this form. I understand that I must inform my doctor if this occurs.
- I consent to undergo the procedure/s or treatment/s as documented on this form.
- I consent to a blood transfusion, if needed
  - Yes
  - No (please tick appropriate box)

**Patient’s Full name ___________________ Patient’s signature ___________________ Date/Time ______________

**Parent/enduring guardian/guardian Full name ___________________ Date/Time ______________

(if desired for a mature minor) Signature ___________________ Date/Time ______________

**Interpreter’s declaration**

Specific language requirements (if any) ___________________

Interpreter services required:  
- Yes
- No

I declare that I have interpreted the dialogue between the patient and health professional to the best of my ability, and have advised the health professional of any concerns about my performance.

**Interpreter’s Full name ___________________ Date/Time ______________

Signature ___________________ 

**Confirmation of consent at pre-admission or admission to hospital**

I confirm that the request and consent for the operation/procedure/treatment above remains current.

Signature ___________________ Date/Time ______________

(same as the consenting person above)
Appendix 2 - Form B

<table>
<thead>
<tr>
<th>Affix hospital identification here</th>
<th>Surname</th>
<th>UMRN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent for a Minor Requiring Parental/Guardian Approval for Treatment or Investigation (Page 1 of 2)</td>
<td>Given names</td>
<td>DOB</td>
</tr>
<tr>
<td></td>
<td>Address</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suburb</td>
<td>Postcode</td>
</tr>
</tbody>
</table>

This form is to be completed giving due consideration to the “Consent to Treatment Policy for the Western Australian Health System”

**Declaration of doctor/proceduralist (to be completed by the clinician obtaining consent)**

Tick the boxes or cross out and initial any changes or information not appropriate to the stated procedure

☐ I have informed the parent/guardian of the child’s medical condition and prognosis. I have also explained the relevant diagnostic treatment options that are available for the child and associated benefits and risks.

☐ I have recommended the treatment/procedures/investigations noted below on this form. I have discussed the proposed procedure/s and outcomes (including irreversibility) with the parent/guardian. The benefits and risks, both general and specific, and the risks of not having the procedure have also been explained to the parent/guardian.

☐ The parent/guardian has been provided with information specific to the procedure identified. He or she has been asked to read information I have provided and to advise me or the doctor/proceduralist (if different person) if further information is required.

☐ An identifiable copy of the information I have provided to the parent/guardian has been kept on the patient’s health care record.

**Treatment/procedure/investigation**

List the treatment/procedures/investigations to be performed, noting correct side/correct site

This procedure requires: ☐ General and/or Regional Anaesthesia ☐ Local Anaesthesia ☐ Sedation

An Anaesthetist will explain the risk of general or regional anaesthesia to you.

**Disclosure of material risks**

Material risk or specific risks particular to this patient that have arisen as a result of our discussions are:

**Signature of doctor/proceduralist obtaining consent**

Full name __________________________ Position/Title __________________________

Signature __________________________ Date __________________________

**Signature of doctor/proceduralist with overall responsibility for treatment (if different)**

Full name __________________________ Position/Title __________________________

Signature __________________________ Date __________________________
## Consent for a Minor Requiring Parental/Guardian Approval for Treatment or Investigation

(Please read the information carefully and tick the following to indicate you have understood and agree with the information provided to you. Any specific concerns should be discussed with your doctor/proceduralist performing the procedure prior to signing the consent form.)

- The doctor has explained the child’s medical condition and prognosis to me. The doctor also explained the relevant diagnostic treatment options that are available to the child and their associated risks, including the risks of not having the procedure.

- The risks of the procedure have been explained to me, including the risks that are specific to the child and the likely outcomes. I have had an opportunity to discuss and clarify any concerns with the doctor or proceduralist.

- I understand that the result/outcome of the treatment/procedure cannot be guaranteed.

- I understand that if immediate life-threatening events happen during the procedure, the child will be treated as necessary to save the child’s life or to prevent serious harm to the child’s health.

- I understand that if the child is treated as a public patient no guarantee can be provided that a particular doctor/proceduralist will perform the procedure and that the doctor/proceduralist performing the procedure may be undergoing training.

- I understand that tissue samples and blood removed as part of the procedure or treatment will be used for diagnostic and common pathology practices (which may include audit, training, test development and research), and will be stored or disposed of sensitively by the hospital.

- I agree for my/this child’s medical record to be accessed by staff involved in the child’s clinical care and for it to be used for approved quality assurance activities, including clinical audit.

- If a staff member is exposed to my/this child’s blood, I consent to a sample of blood being collected and tested for infectious diseases. I understand that I will be informed if the sample is tested, and that I will be given the results of the tests.

- I consent to the child having a blood transfusion  Yes  No (please tick relevant box)

- On behalf of the child, I give consent for my/this child to undergo the procedure/s or treatment/s as documented on this form.

- I understand that I have the right to change my mind at any time before the procedure is undertaken, including after I have signed this form. I understand that I must inform the doctor if this occurs.

### Parent/guardian’s declaration

<table>
<thead>
<tr>
<th>Surname</th>
<th>UMRN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Given names</th>
<th>DOB</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Suburb</th>
<th>Postcode</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Specific language requirements (If any)

 Interpreter services required:  Yes  No

I declare that I have interpreted the dialogue between the parent/guardian and health professional to the best of my ability, and have advised the health professional of any concerns about my performance.

<table>
<thead>
<tr>
<th>Interpreter’s Full name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Confirmation of consent at pre-admission or admission to hospital

I confirm that the request and consent for the operation/procedure/treatment above remains current.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(same as the consenting person above)
Appendix 3 - Form C

Affix hospital identification here

Surname

UMRN

Given names

DOB

Sex

Address

Suburb

Postcode

This form is to be completed giving due consideration to the “Consent to Treatment Policy for the Western Australian Health System”

Reason for the adult being incapable of consent

The patient is incapable of consenting to the procedure/treatment because:
(Tick one of the boxes below)

☐ He/she lacks the legal capacity to be able to understand the nature and effect of the procedure/treatment.
☐ He/she is unconscious/suffers from dementia and cannot indicate whether or not he/she does consent to the procedure/treatment.

Declaration of doctor/proceduralist (to be completed by the clinician obtaining consent)

Tick the boxes or cross out and initial any changes or information not appropriate to the stated procedure

☐ I have informed the person responsible of the patient’s medical condition and prognosis. I have also explained the relevant diagnostic treatment options that are available to the patient and the associated benefits and risks.
☐ I have recommended the treatment/procedures/investigations noted below on this form. I have discussed the proposed procedure/s and outcomes (including irreversibility) with the person responsible. The benefits and risks, both general and specific, and the risks of not having the procedure have also been explained to the person responsible.
☐ The person responsible has been provided with information specific to the procedure identified. He or she has been asked to read information I have provided and to advise me or the doctor/proceduralist (if different person) if further information is required.
☐ An identifiable copy of the information I have provided to the person responsible has been kept on the patient’s health care record.

Treatment/procedure/investigation

List the treatment/procedures/investigations to be performed, noting correct side/correct site

This procedure requires: ☐ General and/or Regional Anaesthesia ☐ Local Anaesthesia ☐ Sedation

An anaesthetist will explain the risk of general or regional anaesthesia to you.

Disclosure of material risks

Material risk or specific risks particular to this patient that have arisen as a result of our discussions are:

Signature of doctor/proceduralist obtaining consent

Full name ___________________________ Position/Title ___________________________

Signature ___________________________ Date ___________________________

Signature of doctor/proceduralist with overall responsibility for treatment (if different)

Full name ___________________________ Position/Title ___________________________

Signature ___________________________ Date ___________________________
Declaration of person responsible/consenting person

Please read the information carefully and tick the following to indicate you have understood and agree with the information provided to you. Any specific concerns should be discussed with the doctor or proceduralist performing the procedure prior to signing the consent form.

☐ The doctor/proceduralist has explained the patient’s medical condition and prognosis to me. The doctor/proceduralist also explained the relevant diagnostic treatment options that are available to the patient and the associated risks, including the risks of not having the procedure.

☐ The risks of the procedure have been explained to me, including the risks that are specific to the patient and the likely outcomes. I have had an opportunity to discuss and clarify any concerns with the doctor/proceduralist.

☐ I understand that the result/outcome of the treatment/procedure cannot be guaranteed.

☐ I understand that if immediate life-threatening events happen during the procedure, the patient will be treated as necessary to save the patient’s life or to prevent serious harm to his/her health.

☐ I understand that if the patient is treated as a public patient, no guarantee can be provided that a particular doctor/proceduralist will perform the procedure and that the doctor/proceduralist performing the procedure may be undergoing training.

☐ I understand that tissue samples and blood removed as part of the procedure or treatment will be used for diagnosis and common pathology practices (which may include audit, training, test development and research), and will be stored or disposed of sensitively by the hospital.

☐ I agree for the patient’s medical record to be accessed by staff involved in the patient’s clinical care and for it to be used for approved quality assurance activities, including clinical audit.

☐ If a staff member is exposed to the patient’s blood, I consent to a sample of blood being collected and tested for infectious diseases. I understand that I will be informed if the sample is tested, and that I will be given the results of the tests.

☐ I consent to the patient having a blood transfusion ☐ Yes ☐ No (please tick relevant box)

☐ On behalf of the patient, I give consent for the patient to undergo the procedure/s or treatment/s as documented on this form.

☐ I understand that I have the right to change my mind at any time before the procedure is undertaken, including after I have signed this form. I understand that I must inform the doctor if this occurs.

Signature of person(s) responsible/consenting person

Consenting person’s full name (1)  Consenting person’s full name (2) (If applicable)

Consenting person’s signature (1)  Consenting person’s signature (2)

Date/Time  Date/Time

Relationship to patient  Relationship to patient

Authority  Authority

(Guardianship and Administration Act 1990, Mental Health Act 1996 – state the relevant category as per the treatment hierarchy)
Appendix 4 - Form D

Affix hospital identification here

<table>
<thead>
<tr>
<th>Surname</th>
<th>UMRN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Given Names</td>
<td>DOB</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Suburb</td>
<td>Postcode</td>
</tr>
</tbody>
</table>

This form is to be completed giving due consideration to the “Consent to Treatment Policy for the Western Australian Health System”

Declaration of anaesthetist obtaining consent (to be completed by the clinician obtaining consent)

Tick the boxes or cross out and initial any changes or information not appropriate to the stated anaesthesia

- [ ] I have informed the patient of the anaesthetic techniques for the proposed procedure noted below, including known benefits and possible complications.
- [ ] I have provided the patient with information specific to the anaesthetic techniques indicated below. The patient has been asked to read information provided and ask questions about anything that is unclear. An identifiable copy of the information I have provided to the patient has been kept on the patient's health care record.
- [ ] I have informed the patient of specific anaesthetic risks particular to this patient, as noted below.

Proposed procedure

List the proposed procedure to be performed

Anaesthetic techniques

Tick the proposed anaesthetic technique/s discussed:

- [ ] General anaesthesia
- [ ] Spinal anaesthesia
- [ ] Epidural anaesthesia / analgesia
- [ ] Nerve blocks
- [ ] Blood transfusion
- [ ] Central lines

Disclosure of material risks

Material risks or specific risks particular to this patient that have arisen as a result of our discussions are documented below.

Signature of anaesthetist obtaining consent

Full name ___________________________ Position/Title ___________________________

Signature ___________________________ Date ___________________________

Signature of anaesthetist providing anaesthesia (if different to the anaesthetist who obtained consent)

Full name ___________________________ Position/Title ___________________________

Signature ___________________________ Date ___________________________
Patient Consent to Anaesthesia (General or Regional)

Patient’s declaration
Please read the information carefully and tick the following to indicate you have understood and agree with the information provided to you. Any specific concerns should be discussed with your doctor or proceduralist performing the procedure prior to signing the consent form.

- The anaesthetist has explained the anaesthetic techniques that may be used for the procedure which is proposed.
- The risks of the anaesthetic techniques that may be used, including the risks that are specific to me, have been explained.
- I have been given patient information sheets for my proposed anaesthetic technique.
- I have had the opportunity to discuss and clarify any concerns about the anaesthetic with an anaesthetist.
- I understand that a different anaesthetist may give the anaesthetic.
- I understand that the anaesthetic, in part or whole, may be given by a qualified doctor who is training in anaesthesia.
- I understand that the specific anaesthetic technique to be used will be confirmed only after I have had discussions with the anaesthetist who is giving the anaesthetic.

Patient’s Full Name ____________________________

Signature ____________________________ Date/Time __________

Parent/enduring guardian/guardian Full name ____________________________
(if desired for a mature minor)

Signature ____________________________ Date/Time __________

Interpreter’s declaration

Specific language requirements (if any) ____________________________________________

Interpreter services required: ☐ Yes ☐ No

I declare that I have interpreted the dialogue between the patient and health professional to the best of my ability, and have advised the health professional of any concerns about my performance.

Interpreter’s Full name ____________________________ Date/Time __________

Signature ____________________________
Appendix 5 - Form E

Affix hospital identification here

<table>
<thead>
<tr>
<th>Surname</th>
<th>UMRN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Given names  DOB  Sex

Address

Suburb  Postcode

This form is to be completed giving due consideration to the “Consent to Treatment Policy for the Western Australian Health System”

Electroconvulsive therapy is proposed for (name of patient) for the following reasons (doctor to list reasons): ________________________________

ELECTROCONVULSIVE TREATMENT (ECT)
ECT is given under a general anaesthetic, so the patient is asleep during the treatment and will not feel or remember anything. A muscle relaxing drug is given once the patient is asleep, to limit body spasms. During ECT, electrodes are put onto the scalp and an electric current is passed briefly through the electrodes to the brain, which causes a seizure (a ‘fit’). Consent is given for a specified number of treatments in one course. Further courses require a new consent form to be completed.

RISKS
These are the most common risks. There may be other unusual risks that have not been listed here. Please ask your psychiatrist if you have any general or specific concerns.

☐ I understand there are risks associated with any anaesthetic (see separate Anaesthetic Consent Form).

☐ I understand that I may have side effects from any of the drugs used. The most common side effects include light-headedness, nausea, skin rash and constipation.

☐ I understand the procedure has the following specific risks and limitations:

Immediately after treatment:
• I may feel nauseated, have some muscle soreness and/or have a headache.
• I will probably be somewhat confused.
• With modern techniques, there is a very small risk of bone fractures or dislocations.
• I may have heart rhythm or blood pressure changes, but these will be monitored closely during and after the procedure and treated if necessary.

Later consequences:
• I may have short-term memory difficulties for some time after the procedure, and find it difficult, for example, to remember recent conversations or things I have just read.
• I may also have some difficulty remembering past events, such as dates, names of friends, phone numbers. If this affects me, it may be mild and may last for an unpredictable length of time. In some people, memory loss may be severe and can even be permanent.
• Some people complain of more severe memory loss, which is generally confined to the period around the time of the ECT treatment. There is no evidence that individuals’ abilities to construct new memories are affected in the long term.
• There is an extremely small risk of death from the procedure.

☐ I understand some of the above risks are more likely if I smoke, am overweight or have heart disease, high blood pressure or diabetes.

DISCLOSURE OF MATERIAL RISK
I understand the following are possible significant risks and complications specific to my personal circumstances and I have considered these in deciding to have this treatment:
## Consent Form for Electroconvulsive Therapy (ECT)

*Page 2 of 2*

<table>
<thead>
<tr>
<th>Affix hospital identification here</th>
<th>Surname</th>
<th>UMRN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent to Treatment Policy for the Western Australian Health System 2011</td>
<td>Given names</td>
<td>DOB</td>
</tr>
<tr>
<td>Consent Form for Electroconvulsive Therapy (ECT)</td>
<td>Address</td>
<td>Suburb</td>
</tr>
</tbody>
</table>

- [ ] I consent to a course of treatments *(patient to complete number of treatments: maximum 12)*
- [ ] I acknowledge the psychiatrist has informed me and provided me with written information about the procedure, available alternative treatments and answered my specific queries and concerns about this treatment.
- [ ] I acknowledge that I have discussed with the psychiatrist any significant risks and complications specific to my personal circumstances and I have considered these in deciding to have this treatment.
- [ ] I understand I can change my mind at any stage, even after a course of treatment has begun, without affecting my future health treatment, or any other treatment of the condition for which ECT has been proposed.
- [ ] I have not been guaranteed the treatment will be successful, and I understand the treatment is not a long-term cure for the condition, so I may relapse in the future.
- [ ] I understand that a doctor other than the specialist psychiatrist may perform the procedure. The doctor treating me will have been appropriately trained in the technique.
- [ ] I have received a copy of this form.
- [ ] If a needle stick/sharps injury occurs to staff during any procedure I give my permission for blood to be taken and tested for HIV and other blood borne disorders. I understand I will be advised and counselled as soon as practicable after the treatment if this has been necessary.

**Patient’s Full name** ___________________________ **Signature** ___________________________ **Date/Time** __________

**Witness to the patient’s signature:** **Full name** ___________________________ **Signature** ___________________________

**Advocate/Carer’s Full name** ___________________________ **Date/Time** __________

**Signature** ___________________________ **Relationship to** ___________________________

**Declaration of doctor**

- [ ] I declare that I have explained the nature and consequences of ECT, and discussed the risks that particularly concern the patient.
- [ ] I have given the patient, and the patient’s carer or advocate where involved, an opportunity to ask questions and I have answered these.

**Full name** ___________________________ **Position/Title** ___________________________

**Signature** ___________________________ **Date** __________

**Involuntary patient or mentally impaired accused (where applicable)**

The treatment has been recommended by the treating psychiatrist and the recommendation is approved by:

**Psychiatrist Full name** ___________________________ **Date/Time** __________

**Signature** ___________________________

**Interpreter’s declaration**

Specific language requirements (If any) ___________________________

Interpreter services required:  [ ] Yes  [ ] No

I declare that I have interpreted the dialogue between the patient/carer/advocate and health professional to the best of my ability, and have advised the health professional of any concerns about my performance.

**Interpreter’s Full name** ___________________________ **Date/Time** __________

**Signature** ___________________________
Appendix 6 - Form F

<table>
<thead>
<tr>
<th>Affix hospital identification here</th>
<th>Surname</th>
<th>UMRN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorisation to Proceed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With Surgery on a Patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Without a Valid Consent Form</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This form is to be completed giving due consideration to the "Consent to Treatment Policy for the Western Australian Health System"

**Reason for seeking authorisation to proceed with surgery on a patient without a valid consent form**

A patient, who has been administered medication that may alter his/her mental state or who may otherwise be incompetent, has arrived at the Operating Theatre/Treatment Room: (Tick one of the boxes below)

- Without a valid consent form; or
- Information recorded on the patient’s consent form is incorrect and requires amendment.

**Note:** A Consent Form is valid if the information is correct in every detail (patient’s details, description of operation or procedure and side and site of procedure of operation), is signed by the patient (or person authorised to give consent in the case of an incompetent patient) and has been witnessed by an appropriate person.

**Declaration of doctor/proceduralist/anaesthetist**

Mr/Ms/Mrs __________________________ (insert name) is scheduled to undergo the following treatment/procedure/investigation (insert): __________________________

Mr/Ms/Mrs __________________________ (insert name) has arrived in the Operating Room without a valid consent form.

In consultation with __________________________ (insert name of doctor/proceduralist) it is considered that the proposed surgery/procedure is urgent and must proceed without a valid Consent Form being completed.

**Reason for urgency/procedure proceeding**

Note: "Urgent treatment means treatment urgently needed by a patient to

- save the patient’s life; or to
- prevent serious damage to the patient’s health; or
- prevent the patient from suffering or continuing to suffer significant pain or distress"

as defined in the section 110ZH Guardianship and Administration Act 1990.

**Documentation and notification (to be completed by doctor/proceduralist/anaesthetist)**

Tick the relevant boxes below:

- I/We have documented the reason/s and rationale for proceeding with the procedure in the patient’s health care record.
- I/We have sought authorisation to proceed with the surgery/procedure from the following Clinical Nurse Manager, Medical Director or Health Service Administrator:

  | Full name: __________________________ | Position: __________________________ |
  | Date/Time: __________________________ | (Clinical Nurse Manager/Medical Director/Health Service Administrator) |

**Signature of doctor/proceduralist/anaesthetist (if different)**

<table>
<thead>
<tr>
<th>Doctor/proceduralist Full name</th>
<th>Signature</th>
<th>Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetist Full name</td>
<td>Signature</td>
<td>Date/Time</td>
</tr>
</tbody>
</table>

Superseded by: OD: 06/7/16
Appendix 7 - Extracts From Relevant Legislation

Disclaimer

The information contained in this Appendix includes extracts from State and Commonwealth legislation relevant to this Consent Policy. It was current at time of publication.

(A) **Criminal Code 1913**

Part IV – Acts injurious to the public in general

Chapter XXII – Offences against morality

s.199 Abortion
s. 306 Female genital mutilation

(B) **Family Law Act 1975 (Commonwealth)**

Part VI – Children

Division 2 – Parental responsibility

(C) **Guardianship and Administration Act 1990**

Part 5 – Guardianship

Division 1 – Appointment of a guardian
Division 2 – Functions of guardians
Division 3 – Limitations on sterilisation of persons under guardianship

or where application for guardianship made

Part 9A – Enduring powers of guardianship

Division 3 – Operation of enduring power of guardianship
Division 4 – Jurisdiction of State Administrative Tribunal

Part 9B – Making of advance health directive

Division 2 – Operation of advance health directive
Division 3 – Jurisdiction of State Administrative Tribunal

Part 9C – Persons responsible for patients

Division 2 – Treatment decisions by persons responsible for patients
Division 3 – Jurisdiction of State Administrative Tribunal

Part 9D – Treatment decisions in relation to persons under legal incapacity

Division 2 – Provision of treatment
Division 3 – Jurisdiction of State Administrative Tribunal
(D) **Mental Health Act 1996**

Part 5 – Treatment of patients
   Division 2 – Informed consent
   Division 3 – Prohibited treatment
   Division 4 – Psychosurgery
   Division 5 – Electroconvulsive therapy
   Division 6 – Other treatment, involuntary patients and mentally impaired accused
   Division 7 – Emergency psychiatric treatment

(E) **Health Act 1911**

Part XIII – Child health and preventive medicine
   s. 334 – Performance of abortions
   s. 335 – Reports to be furnished

(F) **Human Tissue and Transplant Act 1982**

Part II – Donations of tissue by living persons
   Division 3 – Donations from children
   Division 5 – Blood transfusions

(G) **Civil Liability Act 2002**

Part 1A – Liability for harm caused by the fault of a person
   Division 7 – Professional Negligence (Health Professionals)

Copies of the complete versions of each Western Australian Act can be accessed at [www.slp.wa.gov.au](http://www.slp.wa.gov.au).


The legal information is not intended to be comprehensive. Similarly, it is not intended to be, nor should it be relied upon as a substitute for legal advice.

If you have a legal problem you should seek legal advice tailored to your specific circumstances from the Legal and Legislative Services Directorate of the Department of Health (or, in the case of teaching hospitals only, the State Solicitor’s Office) before acting or relying on any of the legal information in this policy.
A. **Criminal Code 1913**

Part IV – Acts injurious to the public in general

Chapter XXII – Offences against morality

**Section 199 – Abortion**

(1) It is unlawful to perform an abortion unless –
   (a) the abortion is performed by a medical practitioner in good faith and with reasonable care and skill; and
   (b) the performance of the abortion is justified under section 334 of the *Health Act 1911*.

(2) A person who unlawfully performs an abortion is guilty of an offence.

Penalty: $50 000.

(3) Subject to section 259, if a person who is not a medical practitioner performs an abortion that person is guilty of a crime and is liable to imprisonment for 5 years.

(4) In this section **medical practitioner** has the same meaning as it has in the *Health Act 1911*.

(5) A reference in this section to performing an abortion includes a reference to -
   (a) attempting to perform an abortion; and
   (b) doing any act with intent to procure an abortion, whether or not the woman concerned is pregnant.

**Section 306 – Female genital mutilation**

(1) In this section –
   **child** means a person under the age of 18 years;
   **female genital mutilation** means—
   (a) the excision or mutilation of the whole or a part of the clitoris, the labia minora, the labia majora, or any other part of the female genital organs;
   (b) infibulation or any procedure that involves the sealing or suturing together of the labia minora or the labia majora; or
   (c) any procedure to narrow or close the vaginal opening but does not include—
      (d) a reassignment procedure within the meaning of the *Gender Reassignment Act 2000* carried out on a person’s genitals by a medical practitioner within the meaning of the *Health Act 1911*; or
      (e) a medical procedure carried out for proper medical purposes.

(2) A person who performs female genital mutilation on another person is guilty of a crime and is liable to imprisonment for 20 years.

(3) It is not a defence to a charge under subsection (2) that the other person, or a parent or guardian of the other person, consented to the mutilation.
(4) A person who takes a child from Western Australia, or arranges for a child to be taken from Western Australia, with the intention of having the child subjected to female genital mutilation is guilty of a crime and is liable to imprisonment for 10 years.

(5) In proceedings for an offence under subsection (4), proof that—
   a) the accused person took a child, or arranged for a child to be taken from Western Australia; and
   b) the child, while out of Western Australia, was subjected to female genital mutilation,

is proof, in the absence of evidence to the contrary, that the accused person took the child, or arranged for the child to be taken, from Western Australia, as the case may be, with the intention of having the child subjected to female genital mutilation.

B. *Family Law Act 1975 (Commonwealth)*

Part VII – Children
Division 1 – Introductory
Subdivision A – What this Division does

Section 60A – What this Division does

This Division contains:

a) a statement of the object of this Part and the principles underlying it, and an outline of this Part (Subdivision B); and

b) provisions relevant to the interpretation and application of this Part (Subdivision C); and

(c) provisions relevant to how this Act applies to certain children (Subdivision D).

Note: The extension and application of this Part is also dealt with in Subdivision F of Division 12.

Subdivision B – Objects, principles and outlines

Section 60B – Objects of Part and principles underlying it

(1) The objects of this Part are to ensure that the best interests of children are met by:

a) ensuring that children have the benefit of both of their parents having a meaningful involvement in their lives, to the maximum extent consistent with the best interests of the child; and

b) protecting children from physical or psychological harm from being subjected to, or exposed to, abuse, neglect or family violence; and

c) ensuring that children receive adequate and proper parenting to help them achieve their full potential; and

(d) ensuring that parents fulfil their duties, and meet their responsibilities, concerning the care, welfare and development of their children.
(2) The principles underlying these objects are that (except when it is or would be contrary to a child’s best interests):

(a) children have the right to know and be cared for by both their parents, regardless of whether their parents are married, separated, have never married or have never lived together; and

(b) children have a right to spend time on a regular basis with, and communicate on a regular basis with, both their parents and other people significant to their care, welfare and development (such as grandparents and other relatives); and

(c) parents jointly share duties and responsibilities concerning the care, welfare and development of their children; and

(d) parents should agree about the future parenting of their children; and

(e) children have a right to enjoy their culture (including the right to enjoy that culture with other people who share that culture).

(3) For the purposes of subparagraph (2)(e), an Aboriginal child’s or Torres Strait Islander child’s right to enjoy his or her Aboriginal or Torres Strait Islander culture includes the right:

(a) to maintain a connection with that culture; and

(b) to have the support, opportunity and encouragement necessary:

   (i) to explore the full extent of that culture, consistent with the child’s age and developmental level and the child’s views; and

   (ii) to develop a positive appreciation of that culture.

Division 2 – Parental responsibility

Section 61A – What this Division does

This Division deals with the concept of parental responsibility including, in particular:

(a) what parental responsibility is; and

(b) who has parental responsibility.

Section 61B – Meaning of parental responsibility

In this Part, parental responsibility, in relation to a child, means all the duties, powers, responsibilities and authority which, by law, parents have in relation to children.

Section 61C – Each parent has parental responsibility (subject to court orders)

(1) Each of the parents of a child who is not 18 has parental responsibility for the child.

Note 1: This section states the legal position that prevails in relation to parental responsibility to the extent to which it is not displaced by a parenting order made by the court. See subsection (3) of this section and subsection 61D (2) for the effect of a parenting order.

Note 2: This section does not establish a presumption to be applied by the court when making a parenting order. See section 61DA for the presumption that the court does apply when making a parenting order.
Note 3: Under section 63C, the parents of a child may make a parenting plan that deals with the allocation of parental responsibility for the child.

(2) Subsection (1) has effect despite any changes in the nature of the relationships of the child’s parents. It is not affected, for example, by the parents becoming separated or by either or both of them marrying or re-marrying.

(3) Subsection (1) has effect subject to any order of a court for the time being in force (whether or not made under this Act and whether made before or after the commencement of this section).

Note: Section 111CS may affect the attribution of parental responsibility for a child.

Section 61D – Parenting orders and parental responsibility

(1) A parenting order confers parental responsibility for a child on a person, but only to the extent to which the order confers on the person duties, powers, responsibilities or authority in relation to the child.

(2) A parenting order in relation to a child does not take away or diminish any aspect of the parental responsibility of any person for the child except to the extent (if any):
   (a) expressly provided for in the order; or
   (b) necessary to give effect to the order.

C. Guardianship and Administration Act 1990

Part 1 – Preliminary

Section 3 – Terms used

(1) In this Act, unless the contrary intention appears —
   advance health directive means —
   (a) an advance health directive made under Part 9B; or
   (b) an instrument recognised as such under section 110ZA;

   enduring guardian means —
   (a) the person who is the enduring guardian under an enduring power of guardianship;
       or
   (b) the persons who are the joint enduring guardians under an enduring power of guardianship,
       and includes a substitute enduring guardian while he or she is the enduring guardian or a joint enduring guardian under an enduring power of guardianship;

   enduring power of guardianship means —
   (a) an enduring power of guardianship made under Part 9A; or
   (b) an instrument recognised as such under section 110O;

   guardian means —
   (a) a person appointed as a guardian (including an alternate guardian) under section 43;
   (b) 2 or more persons appointed as joint guardians under that section; and
(c) the Public Advocate acting under section 99;

guardianship order means an order made under section 43, and includes an order so made which is amended, continued or replaced under any other provision of this Act;

life sustaining measure means a medical, surgical or nursing procedure directed at supplanting or maintaining a vital bodily function that is temporarily or permanently incapable of independent operation, and includes assisted ventilation and cardiopulmonary resuscitation;
palliative care means a medical, surgical or nursing procedure directed at relieving a person’s pain, discomfort or distress, but does not include a life sustaining measure;
treatment means —
(a) medical or surgical treatment, including —
(i) a life sustaining measure; and
(ii) palliative care;
or
(b) dental treatment; or
(c) other health care;
treatment decision, in relation to a person, means a decision to consent or refuse consent to the commencement or continuation of any treatment of the person.

Part 5 Guardianship
Division 1 – Appointment of a guardian
Section 43 – Making of guardianship order
(1) Subject to section 4, where the State Administrative Tribunal is satisfied that a person in respect of whom an application for a guardianship order is made under section 40 -
(a) has attained the age of 18 years;
(b) is –
(i) incapable of looking after his own health and safety;
(ii) unable to make reasonable judgments in respect of matters relating to his person; or
(iii) in need of oversight, care or control in the interests of his own health and safety or for the protection of others;
and
(c) is in need of a guardian,
the Tribunal may by order declare the person to be in need or a guardian, and if it does so shall appoint –
(d) a person to be a plenary guardian or a limited guardian and, if it is expedient, a person to be an alternate guardian; or
(e) persons to be joint plenary guardians or joint limited guardians,
as the case may require, of the person in respect of whom the application is made.
(2) Where under subsection (1) the State Administrative Tribunal declares that a person is in need of a guardian, it shall also declare the matter or matters set out in paragraph (b) of that subsection of which it is satisfied.

(2a) Subject to section 4, where the State Administrative Tribunal is satisfied that a person in respect of whom an application for a guardianship order is made under section 40 —

(a) has attained the age of 17 but not 18 years; and

(b) will, when he attains the age of 18 years, be —

(i) incapable of looking after his own health and safety; or

(ii) unable to make reasonable judgements in respect of matters relating to his person; or

(iii) in need of oversight, care or control in the interests of his own health and safety or for the protection of others; and

(c) will, when he attains the age of 18 years, be in need of a guardian, the Tribunal may by order declare the person will be in need of a guardian when he attains the age of 18 years, and if it does so shall appoint —

(d) a person to be a plenary guardian or a limited guardian and, if it is expedient, a person to be an alternate guardian; or

(e) persons to be joint plenary guardians or joint limited guardians, as the case may require, of the person in respect of whom the application is made.

(2b) Where under subsection (2a) the State Administrative Tribunal declares that a person will be in need of a guardian, it shall also declare the matter or matters set out in paragraph (b) of that subsection of which it is satisfied.

(2c) An appointment made under subsection (2a) in respect of a person comes into operation on the day on which the person attains the age of 18 years.

(3) An appointment under subsection (1) or (2a) may be made subject to such conditions and restrictions as the State Administrative Tribunal thinks fit.

(4) An order appointing a limited guardian shall specify the functions that are vested in the limited guardian under section 46.

Division 2 – Functions of guardians

Section 45 – Authority of plenary guardian

(1) Subject to section 43(3), where a person is appointed as a plenary guardian, or 2 or more persons are appointed as joint plenary guardians, he or they have all of the functions in respect of the person of the represented person that are, under the Family Court Act 1997, vested in a person in whose favour has been made —

(a) a parenting order which allocates parental responsibility for a child; and
(b) a parenting order which provides that a person is to share parental responsibility for a child, as if the represented person were a child lacking in mature understanding, but a plenary guardian does not, and joint plenary guardians do not, have the right to chastise or punish a represented person.

(2) Without limiting subsection (1), a plenary guardian may do any of the following —
(a) decide where the represented person is to live, whether permanently or temporarily;
(b) decide with whom the represented person is to live;
(c) decide whether the represented person should work and, if so, the nature or type of work, for whom he is to work and matters related thereto;
(d) subject to Subsection (4) make treatment decisions for the represented person;
(e) decide what education and training the represented person is to receive;
(f) decide with whom the represented person is to associate;
(g) as the next friend of the represented person, commence, conduct or settle any legal proceedings on behalf of the represented person, except proceedings relating to the estate of the represented person; and
(h) as the guardian ad litem of the represented person, defend or settle any legal proceedings taken against the represented person, except proceedings relating to the estate of the represented person.

(3) A plenary guardian cannot do any of the following on behalf of the represented person —
(a) vote in any election;
(b) consent, under section 17 of the Adoption Act 1994, to the adoption of a child or under section 69(1) (a) (ii) of that Act to the adoption of a represented person;
(da) consent, under section 21(2) (d) of the Surrogacy Act 2008, to the making of a parentage order under that Act; or
(d) under the Marriage Act 1961 of the Commonwealth, give consent in relation to the marriage of a minor, sign a notice of intended marriage or take part in the solemnization of a marriage.

(4) A plenary guardian cannot consent to the sterilization of a represented person except in accordance with Division 3.

(4) A plenary guardian may not make a will or other testamentary disposition on behalf of a represented person but this subsection does not affect the operation of section 111A.

Section 46 – Authority of limited guardian
Subject to section 43(3), where a person is appointed as a limited guardian, or 2 or more persons are appointed as joint limited guardians, he or they have, in respect of the person of the represented person, such of the functions mentioned in section 45 as the State Administrative Tribunal vests in him or them in the guardianship order.
Division 3 – Limitations on sterilisation of persons under guardianship or where application for guardianship made

Section 57 – Prerequisites for sterilisation of persons to whom this Division applies
(1) A person shall not carry out or take part in any procedure for the sterilisation of a represented person unless —
   (a) both the guardian of the represented person and the State Administration Tribunal have consented in writing to the sterilisation;
   (b) all rights of appeal in respect of a determination under section 63 have lapsed or been exhausted; and
   (c) the sterilisation is carried out in accordance with any condition imposed under this Act.
(2) Notwithstanding section 259 of The Criminal Code, a person who knows that an application has been made for a guardianship order in respect of a person shall not carry out or take part in any procedure for the sterilisation of that person before—
   (a) the application has been finally dealt with by the State Administrative Tribunal; and
   (b) all rights of appeal in respect of a determination under section 43 have lapsed or been exhausted.
Penalty applicable to subsections (1) and (2): $4 000 and imprisonment for 2 years.

Section 58 – Restriction on guardian’s consent
(1) A guardian shall not consent to the sterilisation of a represented person unless the consent of the State Administrative Tribunal has been first obtained.
(2) The consent of the guardian may be given subject to compliance with any condition.

Section 59 – Application for consent
(1) A represented person, his guardian or the Public Advocate may apply to the State Administrative Tribunal for its consent to the carrying out of a procedure for the sterilisation of the represented person.

Part 9A — Enduring powers of guardianship

Division 1 — Preliminary matters

Section 110B – Appointing enduring guardian
A person who has reached 18 years of age and has full legal capacity may make an enduring power of guardianship appointing —
   (a) a person as the enduring guardian of the person; or
   (b) 2 or more persons as the joint enduring guardians of the person.
Section 110C – Substitute enduring guardians
(1) An appointor may, in the enduring power of guardianship, appoint one or more persons to be substitute enduring guardians.

(2) A substitute enduring guardian becomes the enduring guardian or a joint enduring guardian (as the case may be) in the circumstances specified in the enduring power of guardianship.

Section 110D – Who is eligible to be appointed
A person is eligible to be appointed under section 110B or 110C(1) if the person has reached 18 years of age and has full legal capacity.

Section 110E – Formal requirements
(1) An enduring power of guardianship is not valid unless —
   (a) it is in the form or substantially in the form prescribed by the regulations; and
   (b) it is signed by the appointor or by another person in the presence of, and at the direction of, the appointor; and
   (c) the signature referred to in paragraph (b) is witnessed by 2 persons —
      (i) both of whom are authorised by law to take declarations; or
      (ii) of whom —
         (I) one is authorised by law to take declarations; and
         (II) the other has the qualifications specified in subsection (2);
   and
   (d) it is signed by the witnesses referred to in paragraph (c) in the presence of —
      (i) the appointor; and
      (ii) the person who signed it at the appointor’s direction (if applicable); and
      (iii) each other; and
   and
   (e) it is signed by each person being appointed as an enduring guardian or substitute enduring guardian (an appointee) to indicate the appointee’s acceptance of the appointment; and
   (f) the signature of the appointee is witnessed by 2 persons —
      (i) both of whom are authorised by law to take declarations; or
      (ii) of whom —
         (I) one is authorised by law to take declarations; and
         (II) the other has the qualifications specified in subsection (2); and
   and
   (g) it is signed by the witnesses referred to in paragraph (f) in the presence of the appointee and each other.
(2) A witness referred to in subsection (1)(c)(ii)(II) or (f)(ii)(II) must be a person —
   (a) who has reached 18 years of age; and
   (b) who is not —
      (i) the appointor; or
      (ii) the person who signed the enduring power of guardianship at the appointor’s
direction (if applicable); or
      (iii) an appointee.

Division 3 — Operation of enduring power of guardianship

Section 110F – When enduring guardian may act
An enduring power of guardianship has effect, subject to its terms, at any time the
appointor is unable to make reasonable judgments in respect of matters relating to his or
her person.

Section 110G – Functions generally
(1) Subject to this section, an enduring guardian has the same functions under
section 45(1) and (2), and is subject to the same limitations under section 45(3) and
(4), in relation to the appointor as a plenary guardian has and is subject to in relation
to a represented person.
(2) An enduring power of guardianship may limit the functions of the enduring guardian to
the functions specified in the power.
(3) An enduring power of guardianship may limit the circumstances in which the enduring
guardian may act to the circumstances specified in the power.
(4) An enduring power of guardianship may include directions about how the enduring
guardian is to perform any of his or her functions.

Section 110H – Certain provisions apply in relation to enduring guardian and
appointor
The following provisions apply (with the necessary changes) in relation to an enduring
guardian and appointor as if they were a guardian and represented person respectively —
   (a) sections 48 to 51;
   (b) section 53(a);
   (c) subject to the terms of the enduring power of guardianship, section 54 as if it were
not subject to section 85;
   (d) Part 5 Division 3 other than section 57(2).
Section 110I – Priority of enduring power of guardianship

(1) To the extent an enduring power of guardianship relates to the making of a treatment decision for the appointor, the priority to be given to the power is determined in accordance with section 110ZJ.

(2) To the extent an enduring power of guardianship relates to the performance of any other function in relation to the appointor, the priority to be given to the power is determined in accordance with section 119.

Division 4 — Jurisdiction of State Administrative Tribunal
Section 110J – Who may apply
A person who, in the opinion of the State Administrative Tribunal, has a proper interest in the matter may apply to the Tribunal for a decision under this Division.

Section 110K – Declaration about validity of enduring power of guardianship

(1) The State Administrative Tribunal may declare that an enduring power of guardianship is valid or invalid.

(2) A declaration made under subsection (1) has effect according to its terms.

Section 110L – Declaration of incapacity of appointor

(1) The State Administrative Tribunal may declare that the appointor under an enduring power of guardianship is unable to make reasonable judgments in respect of matters relating to his or her person.

(2) A declaration made under subsection (1) has effect according to its terms.

(3) The Tribunal may revoke a declaration made under subsection (1).

Section 110M – Directions as to construction of terms etc.

The State Administrative Tribunal may give directions as to matters connected with —

(a) the exercise of an enduring power of guardianship; or

(b) the construction of the terms of an enduring power of guardianship.

Section 110N – Revocation or variation of enduring power of guardianship

(1) The State Administrative Tribunal may make an order —

(a) revoking an enduring power of guardianship; or

(b) revoking the appointment of one or some of the persons who are joint enduring guardians under an enduring power of guardianship if the person or each of the persons —

(i) wishes to be discharged; or

(ii) has been guilty of such neglect or misconduct or of such default as, in the opinion of the Tribunal, renders the person unfit to continue as an enduring guardian; or
(iii) appears to the Tribunal to be incapable by reason of mental or physical incapacity of carrying out the person’s duties;

or

(c) revoking or varying any of the terms of an enduring power of guardianship.

(2) If the Tribunal makes an order under subsection (1)(b), subject to the terms of the enduring power of guardianship, the remaining enduring guardian or guardians may act under the power.

(3) An order made under subsection (1) may be expressed to come into effect at a time earlier than immediately after it is made.

Section 110O – Recognition of instrument created in another jurisdiction

(1) The State Administrative Tribunal may make an order recognising an instrument created under a law of another jurisdiction as an enduring power of guardianship under this Part if satisfied the instrument corresponds sufficiently, in form and effect, to an enduring power of guardianship made under this Part.

(2) The Tribunal may revoke an order made under subsection (1).

Part 9B — Advance health directives

Division 1 — Making of advance health directive

Section 110P – Making advance health directive

A person who has reached 18 years of age and has full legal capacity may make an advance health directive containing treatment decisions in respect of the person’s future treatment.

Section 110Q – Formal requirements

(1) An advance health directive is not valid unless —

(a) it is in the form or substantially in the form prescribed by the regulations; and

(b) the maker is encouraged to seek legal or medical advice; and

(c) it is signed by its maker or by another person in the presence of, and at the direction of, its maker; and

(d) the signature referred to in paragraph (c) is witnessed by 2 persons —

(i) both of whom are authorised by law to take declarations; or

(ii) of whom —

(I) one is authorised by law to take declarations; and

(II) the other has the qualifications specified in subsection (3); and

(e) it is signed by the witnesses in the presence of —

(i) its maker; and

(ii) the person who signed it at its maker’s direction (if applicable); and

(iii) each other.

(2) Despite subsection (1)(b), the validity of an advance health directive is not affected by a failure to comply with subsection (1)(b).
Consent to Treatment Policy for the Western Australian Health System 2011

(3) A witness referred to in subsection (1)(d)(ii)(II) must be a person —
   (a) who has reached 18 years of age; and
   (b) who is not —
      (i) the maker of the advance health directive; or
      (ii) the person who signed the directive at its maker’s direction (if applicable).

Section 110QA – Maker may indicate in directive whether advice obtained
The form prescribed by the regulations for section 110Q(1)(a) must include provision for the maker, if the maker wishes —
   (a) to indicate whether the maker obtained legal or medical advice about the making of the directive; and
   (b) if so, to identify from whom the maker obtained the advice.

Section 110R – Requirements in relation to treatment decision in advance health directive
(1) A treatment decision in an advance health directive is invalid if the treatment decision —
   (a) is not made voluntarily; or
   (b) is made as a result of inducement or coercion.
(2) A treatment decision in an advance health directive is invalid if, at the time the directive is made, its maker does not understand —
   (a) the nature of the treatment decision; or
   (b) the consequences of making the treatment decision.

Division 2 — Operation of advance health directive
Section 110S – Operation generally
(1) A treatment decision in an advance health directive operates in respect of the treatment to which it applies —
   (a) at any time the maker of the directive is unable to make reasonable judgments in respect of that treatment; and
   (b) as if —
      (i) the treatment decision had been made by the maker at that time; and
      (ii) the maker were of full legal capacity.
(2) Subject to subsection (3), a treatment decision in an advance health directive operates only in the circumstances specified in the directive.
(3) Subject to subsection (4), a treatment decision in an advance health directive does not operate if circumstances exist or have arisen that —
   (a) the maker of that directive would not have reasonably anticipated at the time of making the directive; and

Superseded by:
OD: 0657/16
(b) would have caused a reasonable person in the maker’s position to have changed his or her mind about the treatment decision.

(4) In determining whether or not subsection (3) applies in relation to a treatment decision that is in an advance health directive, the matters that must be taken into account include the following —

(a) the maker’s age at the time the directive was made and at the time the treatment decision would otherwise operate;
(b) the period that has elapsed between those times;
(c) whether the maker reviewed the treatment decision at any time during that period and, if so, the period that has elapsed between the time of the last such review and the time at which the treatment decision would otherwise operate;
(d) the nature of the condition for which the maker needs treatment, the nature of that treatment and the consequences of providing and not providing that treatment.

(5) For the purpose of determining whether or not subsection (3) applies in relation to a treatment decision that is in an advance health directive, subject to the terms of the directive, any of the following persons may be consulted —

(a) if the maker has an enduring guardian — the enduring guardian;
(b) if the maker has a guardian — the guardian;
(c) a person who has a relationship with the maker described in section 110ZD(3)(a) to (d);
(d) any other person considered appropriate in the circumstances.

(6) Subject to section 110T, a treatment decision in an advance health directive is taken to have been revoked if the maker of the directive has changed his or her mind about the treatment decision since making the directive.

Section 110T – Effect of subsequent enduring power of guardianship

For the purposes of this Act —

(a) a treatment decision in an advance health directive is not taken to have been revoked; and
(b) the maker of the directive is not taken to have changed his or her mind about the treatment decision since making the directive, merely because the maker subsequently makes an enduring power of guardianship (whether about the same matter as the treatment decision or a different matter).

Section 110U – Priority of treatment decision in advance health directive

The priority to be given to a treatment decision in an advance health directive is determined in accordance with section 110ZJ.

Division 3 — Jurisdiction of State Administrative Tribunal

Section 110V – Who may apply

A person who, in the opinion of the State Administrative Tribunal, has a proper interest in the matter may apply to the Tribunal for a decision under this Division.
Section 110W – Declaration about validity of directive or treatment decision
(1) The State Administrative Tribunal may declare that —
   (a) an advance health directive; or
   (b) a treatment decision in an advance health directive,
       is valid or invalid.
(2) A declaration made under subsection (1) has effect according to its terms.

Section 110X – Declaration of incapacity of maker
(1) The State Administrative Tribunal may declare that the maker of an advance health
directive is unable to make reasonable judgments in respect of the treatment to which
a treatment decision in the directive applies.
(2) A declaration made under subsection (1) has effect according to its terms.
(3) The Tribunal may revoke a declaration made under subsection (1).

Section 110Y – Directions as to construction of terms etc.
The State Administrative Tribunal may give directions as to matters connected with —
   (a) the giving of effect to a treatment decision in an advance health directive; or
   (b) the construction of the terms of an advance health directive.

Section 110Z – Declaration that treatment decision has been revoked
(1) The State Administrative Tribunal may declare that a treatment decision in an advance
health directive is taken to have been revoked under section 110S(6).
(2) A declaration made under subsection (1) has effect according to its terms.
(3) The Tribunal may revoke a declaration made under subsection (1).

Section 110ZA – Recognition of instrument created in another jurisdiction
(1) The State Administrative Tribunal may make an order recognising an instrument
created under a law of another jurisdiction as an advance health directive made under
this Part if satisfied the instrument corresponds sufficiently, in form and effect, to an
advance health directive made under this Part.
(2) The Tribunal may revoke an order made under subsection (1).

Section 110ZB – Common law preserved
This Part does not affect the common law relating to a person’s entitlement to make
treatment decisions in respect of the person’s future treatment.
Part 9C — Persons responsible for patients

Division 1 — Preliminary matters

Section 110ZC — Meaning of “patient”

In this Part —

patient means a person who needs treatment.

Division 2 — Treatment decisions by persons responsible for patients

Section 110ZD — Circumstances in which person responsible may make treatment decision

(1) If a patient is unable to make reasonable judgments in respect of any treatment proposed to be provided to the patient, the person responsible for the patient under subsection (2) may make a treatment decision in respect of the treatment.

(2) The person responsible for the patient is the first in order of the persons listed in subsection (3) who —

(a) is of full legal capacity; and

(b) is reasonably available; and

(c) is willing to make a treatment decision in respect of the treatment.

(3) For subsection (2), the persons are the following —

(a) the patient’s spouse or de facto partner if that person —

(i) has reached 18 years of age; and

(ii) is living with the patient;

(b) the patient’s nearest relative who maintains a close personal relationship with the patient;

(c) the person who —

(i) has reached 18 years of age; and

(ii) is the primary provider of care and support (including emotional support) to the patient, but is not remunerated for providing that care and support;

(d) any other person who —

(i) has reached 18 years of age; and

(ii) maintains a close personal relationship with the patient.

(4) For subsection (3)(b), the patient’s nearest relative is the first in order of priority of the following relatives of the patient who has reached 18 years of age —

(a) the spouse or de facto partner;

(b) a child;

(c) a parent;

(d) a sibling.
(5) For subsection (3)(b) and (d)(ii), a person maintains a close personal relationship with the patient only if the person —
   (a) has frequent contact of a personal (as opposed to a business or professional) nature with the patient; and
   (b) takes a genuine interest in the patient’s welfare.

(6) For subsection (3)(c)(ii), a person is not remunerated for providing care and support to the patient although the person receives a carer payment or other benefit from the Commonwealth or a State or Territory for providing home care for the patient.

(7) The person responsible for the patient cannot consent to the sterilisation of the patient.

(8) When making a treatment decision for the patient, the person responsible for the patient must act according to the person’s opinion of the best interests of the patient.

(9) A treatment decision made by the person responsible for the patient has effect as if —
   (a) the treatment decision had been made by the patient; and
   (b) the patient were of full legal capacity.

Section 110ZEA – Priority of treatment decision of person responsible
The priority to be given to a treatment decision of a person responsible for a patient under section 110ZD is determined in accordance with section 110ZJ.

Division 3 — Jurisdiction of State Administrative Tribunal

Section 110ZFA – Who may apply
A person who, in the opinion of the State Administrative Tribunal, has a proper interest in the matter may apply to the Tribunal for a decision under this Division.

Section 110ZG – Declaration that person responsible may make treatment decision
(1) The State Administrative Tribunal may declare —
   (a) that a patient is unable to make reasonable judgments in respect of the treatment proposed to be provided to the patient; and
   (b) that the person identified in the declaration is the person responsible for the patient under section 110ZD.

(2) A declaration made under subsection (1) has effect according to its terms.

(3) The Tribunal may revoke a declaration made under subsection (1).

Part 9D — Treatment decisions in relation to patients under legal incapacity

Division 1 — Preliminary matters

Section 110ZHA – Terms used in this Part
In this Part —

advance health directive includes a directive given by a person under the common law containing treatment decisions in respect of the person’s future treatment;

health professional has the meaning given to that term in the Civil Liability Act 2002 section 5PA;
patient means a person who needs treatment;
urgent treatment means treatment urgently needed by a patient —
(a) to save the patient’s life; or
(b) to prevent serious damage to the patient’s health; or
(c) to prevent the patient from suffering or continuing to suffer significant pain or distress,
but does not include the sterilisation of the patient.

Division 2 — Provision of treatment

Section 110ZI – Urgent treatment generally
(1) Subsection (2) applies if —
   (a) a patient needs urgent treatment; and
   (b) the patient is unable to make reasonable judgments in respect of the treatment; and
   (c) it is not practicable for the health professional who proposes to provide the treatment to determine whether or not the patient has made an advance health directive containing a treatment decision that is inconsistent with providing the treatment; and
   (d) it is not practicable for the health professional to obtain a treatment decision in respect of the treatment from the patient’s guardian or enduring guardian or the person responsible for the patient under section 110ZD.

(2) The health professional may provide the treatment to the patient in the absence of a treatment decision in relation to the patient.

Section 110ZIA – Urgent treatment after attempted suicide
(1) Subsection (2) applies if —
   (a) a patient needs urgent treatment; and
   (b) the patient is unable to make reasonable judgments in respect of the treatment; and
   (c) the health professional who proposes to provide the treatment reasonably suspects that the patient has attempted to commit suicide and needs the treatment as a consequence.

(2) The health professional may provide the treatment to the patient despite —
   (a) the patient having made an advance health directive containing a treatment decision that is inconsistent with providing the treatment; or
   (b) the patient’s guardian or enduring guardian or the person responsible for the patient under section 110ZD having made such a treatment decision in relation to the patient.
Section 110ZJ – Order of priority of persons who may make treatment decision in relation to patient

(1) Subject to sections 110ZI and 110ZIA, this section applies if a patient is unable to make reasonable judgments in respect of any treatment proposed to be provided to the patient.

(2) If the patient has made an advance health directive containing a treatment decision in respect of the treatment, whether or not the treatment is provided to the patient must be decided in accordance with the treatment decision.

(3) If –
   (a) subsection (2) does not apply; and
   (b) the patient has an enduring guardian who –
       (i) is authorised to make a treatment decision in respect of the treatment; and
       (ii) is reasonably available; and
       (iii) is willing to make a treatment decision in respect of the treatment,
       whether or not the treatment is provided to the patient must be decided by the enduring guardian.

(4) If —
   (a) subsections (2) and (3) do not apply; and
   (b) the patient has a guardian who —
       (i) is authorised to make a treatment decision in respect of the treatment; and
       (ii) is reasonably available; and
       (iii) is willing to make a treatment decision in respect of the treatment,
       whether or not the treatment is provided to the patient must be decided by the guardian.

(5) If —
   (a) subsections (2) to (4) do not apply; and
   (b) there is a person responsible for the patient under section 110ZD,
       whether or not the treatment is provided to the patient must be decided by the person responsible.

Section 110ZK – Reliance by health professional on treatment decision

(1) In this section —
   take treatment action means —
   (a) to commence or continue any treatment of a patient; or
   (b) to not commence or to discontinue any treatment of a patient.

(2) If a health professional —
   (a) takes treatment action —
       (i) reasonably believing that the patient is unable to make reasonable judgments in respect of the treatment action; and
       (ii) relying in good faith on what is purportedly a treatment decision —
(I) in an advance health directive made by the patient; or
(II) made by the patient’s guardian or enduring guardian or the person responsible for the patient under section 110ZD;

or

(b) takes treatment action —

(i) in circumstances where it is reasonable for the health professional to rely on some other health professional having ascertained whether the treatment action is in accordance with a treatment decision; and

(ii) reasonably assuming that some other health professional has ascertained that the treatment action is in accordance with a treatment decision, the health professional is taken for all purposes to take the treatment action in accordance with a treatment decision that has effect as if —

(c) it had been made by the patient; and

(d) the patient were of full legal capacity.

(3) For subsection (2)(a)(ii), a health professional is taken to have relied in good faith on what was purportedly a treatment decision if, after considering whether or not to rely on it, the health professional acted honestly in relying on it.

(4) For the purpose of determining under subsection (2)(b)(ii) whether the health professional’s assumption was reasonable, the following matters must be taken into account —

(a) whether the health professional sighted any written evidence that some other health professional had ascertained that the treatment action was in accordance with the treatment decision;

(b) anything else relevant to the determination.

Section 110ZL – Validity of certain treatment decisions

If a health professional —

(a) commences or continues palliative care in relation to a patient; or

(b) does not commence or discontinues any treatment of a patient, in accordance with a treatment decision that is —

(c) in an advance health directive made by the patient; or

(d) made by the patient’s guardian or enduring guardian or the person responsible for the patient under section 110ZD,

the health professional is taken for all purposes to have done so in accordance with a valid treatment decision, even if an effect of doing so is to hasten the death of the patient.
Division 3 — Jurisdiction of State Administrative Tribunal

Section 110ZM – Who may apply
A person who, in the opinion of the State Administrative Tribunal, has a proper interest in the matter may apply to the Tribunal for a decision under this Division.

Section 110ZN – Declaration as to who may make treatment decision
(1) The State Administrative Tribunal may declare whether section 110ZJ (2), (3), (4) or (5) applies in respect of any treatment proposed to be provided to a patient.
(2) A declaration made under subsection (1) has effect according to its terms.
(3) The Tribunal may revoke a declaration made under subsection (1).

D. Mental Health Act 1996

Part 5 – Treatment of patients
Division 2 – Informed consent
Section 95 – Requirements for informed consent
(1) For the purposes of this Division a patient gives informed consent to treatment only if—
   (a) the requirements of this Division have been complied with; and
   (b) the consent was freely and voluntarily given.
(2) A failure to offer resistance to treatment does not of itself constitute consent to treatment.

Section 96 – Capacity to give informed consent
A patient is incapable of giving informed consent unless he or she is capable of understanding—
   (a) the things that are required by this Division to be communicated to him or her;
   (b) the matters involved in the decision; and
   (c) the effect of giving consent.

Section 97 – Explanation to be given
(1) Before an informed consent is given the patient is to be given a clear explanation of the proposed treatment—
   (a) containing sufficient information to enable the patient to make a balanced judgment about the treatment;
   (b) identifying and explaining any medication or technique about which there is insufficient knowledge to justify its being recommended or to enable its effect to be reliably predicted; and
   (c) warning the patient of any risks inherent in the treatment.
(2) The extent of the information that a patient is required to be given under this section is limited to information that a reasonable person in the patient’s position would be likely to regard as significant unless it is, or reasonably should be, known that the patient would be likely to regard other information as significant.

(3) The requirements of subsection (1) apply irrespective of any privilege that a person may assert.

(4) Anything that is required by this section to be communicated to a patient is not to be considered to have been effectively communicated unless—
   (a) it is in a language or form that is readily understood by the patient using a competent interpreter if necessary; and
   (b) it is so expressed as to facilitate his or her understanding of what is required to be communicated.

Section 98 – Sufficient time to be given
Informed consent is not to be considered to have been given unless the patient has been allowed sufficient time to consider the matters involved in the decision and obtain such advice and assistance as may be desired.

Division 3 – Prohibited treatment
Section 99 - Offence to administer certain treatment
(1) A person is not to administer to or perform on another person—
   (a) deep sleep therapy; or
   (b) insulin coma or sub-coma therapy.

(2) A person who contravenes subsection (1) commits a crime.
   Penalty: Imprisonment for 5 years.

Division 4 – Psychosurgery
Section 100 – Meaning of “psychosurgery”
(1) In this Division—
   psychosurgery means—
   (a) the use of a surgical technique or procedure, or of intracerebral electrodes, to create in a person’s brain a lesion that, by itself or together with any other lesion created at the same time or any other time, is intended to permanently alter the thoughts, emotions, or certain behaviour of the person; or
   (b) the use of intracerebral electrodes to stimulate a person’s brain, without creating a lesion, with the intent that, by itself or together with any other such stimulation at the same time or any other time, the stimulation will, temporarily, influence or alter the thoughts, emotions, or certain behaviour of the person.

(2) The behaviour referred to in subsection (1) (a) and (b) does not include behaviour considered to be secondary to a paroxysmal cerebral dysrhythmia.
Section 101 - Prerequisites to psychosurgery

(1) A person is not to perform psychosurgery on another person unless—
   (a) that other person has given informed consent to it; and
   (b) it has been approved by the Mental Health Review Board constituted as required by section 130.

(2) A person who contravenes subsection (1) commits a crime.
   Penalty: Imprisonment for 5 years.

(3) It is no defence to a charge of an offence against this section that the person on whom psychosurgery was performed refused to give, or was incapable of giving, informed consent.

Section 102 - Applications for approval to perform psychosurgery

(1) An application for the Mental Health Review Board to approve of the performance of psychosurgery is to be made in writing.

(2) For the purposes of proceedings before the Board to consider the application—
   (a) the applicant and the person on whom the psychosurgery is proposed to be performed are parties to the proceedings; and
   (b) the Board may also treat as a party any other person who the Board is satisfied has a sufficient interest in the matter.

Division 5 — Electroconvulsive therapy

Subdivision 1 — Involuntary patients and mentally impaired accused

Section 104 – Prerequisites

(1) A person is not to perform electroconvulsive therapy on—
   (a) an involuntary patient; or
   (b) a mentally impaired accused who is in an authorised hospital,
      unless—
      (c) it has been recommended by the treating psychiatrist; and
      (d) the recommendation is approved by another psychiatrist.
   Penalty: $10 000 and imprisonment for 2 years.

(2) Subsection (1) does not apply if the electroconvulsive therapy is given as emergency psychiatric treatment and the requirements of Division 7 have been fulfilled.

Section 105 – Matters for consideration by psychiatrist

Before a psychiatrist approves a recommendation for the purposes of 104(1)(d), the psychiatrist is required—
   (a) to be satisfied that the proposed therapy has clinical merit and would be appropriate in the circumstances;
   (b) to decide whether or not the person concerned has the capacity to give informed consent to the proposed therapy;
(c) if the person has the capacity —
   (i) to ascertain whether or not that consent has been given; and
   (ii) to have regard to whether or not that consent has been given.

Subdivision 2 – Other patients
Section 107 – Informed consent required
(1) A person is not to perform electroconvulsive therapy on a person who is neither —
   (a) an involuntary patient; nor
   (b) a mentally impaired accused who is in an authorised hospital,
       unless the person on whom the therapy is performed has given informed consent to it.
       Penalty: $10 000 and imprisonment for 2 years.
(2) Subsection (1) does not apply if the electroconvulsive therapy is given as emergency psychiatric treatment and the requirements of Division 7 have been fulfilled.
(3) It is no defense to a charge of an offence against subsection (1) of having performed electroconvulsive therapy on a person without the person having given informed consent to it that the person refused to give, or was incapable of giving, informed consent.

Division 6 – Other treatment, involuntary patients and mentally impaired accused
Section 108 – Meaning of “psychiatric treatment” in this Division
References in this Division to psychiatric treatment are to psychiatric treatment that does not involve —
   (a) treatment that is prohibited by section 99;
   (b) psychosurgery; or
   (c) electroconvulsive therapy.

Section 109 – Consent not required for psychiatric treatment
An involuntary patient, or a mentally impaired accused that is in an authorised hospital, may be given psychiatric treatment without his or her consent.

Section 110 – Medical treatment may be approved by the Chief Psychiatrist
(1) A person who is in an authorised hospital as —
   (a) an involuntary patient; or
   (b) a mentally impaired accused,
       may be given medical treatment, other than psychiatric treatment or treatment referred to in section 108, if it has been approved in writing by the Chief Psychiatrist.
(2) Subsection (1) does not limit a power conferred by any other written law by which a person may consent to the medical treatment of another person.
Division 7 — Emergency psychiatric treatment

Section 113 – Definition

(1) In this Division—

emergency psychiatric treatment means psychiatric treatment that it is necessary to give to a person—

(a) to save the person’s life; or

(b) to prevent the person from behaving in a way that can be expected to result in serious physical harm to the person or any other person.

(2) Psychosurgery is not permissible as an emergency psychiatric treatment.

Section 114 – Consent or approval dispensed with

Treatment that is emergency psychiatric treatment may be given without any consent or approval that would be required if it were not emergency psychiatric treatment.

Section 115 – Duties of person giving emergency treatment

A person who under section 114 gives treatment without any consent or approval that would have been required had the treatment not been emergency psychiatric treatment, is to —

(a) ensure that a record is made of the treatment including —

(i) particulars of the treatment;

(ii) the time and place at which, and the circumstances in which, the treatment was given; and

(iii) the names of the person given treatment and the persons involved in giving the treatment; and

(b) send to the Mental Health Review Board a report of the giving of the treatment including the information that is required by paragraph (a) to be recorded.

E. Health Act 1911

Part XIII – Child health and preventive medicine

Section 334 – Performance of Abortions

(1) A reference in this section to performing an abortion includes a reference to —

(a) attempting to perform an abortion; and

(b) doing any act with intent to procure an abortion, whether or not the woman concerned is pregnant.

(2) No person, hospital, health institution, other institution or service is under a duty, whether by contract or by statutory or other legal requirement, to participate in the performance of an abortion.

(3) Subject to subsections (4) and (7), the performance of an abortion is justified for the purposes of section 199(1) of The Criminal Code if, and only if:

(a) the woman concerned has given informed consent; or
(b) the woman concerned will suffer serious personal, family or social consequences if the abortion is not performed; or
(c) serious danger to the physical or mental health of the woman concerned will result if the abortion is not performed; or
(d) the pregnancy of the woman concerned is causing serious danger to her physical or mental health.

(4) Subsection (3)(b), (c) or (d) do not apply unless the woman has given informed consent or in the case of paragraphs (c) or (d) it is impracticable for her to do so.

(5) In this section —

informed consent means consent freely given by the woman where —
(a) a medical practitioner has properly, appropriately and adequately provided her with counselling about the medical risk of termination of pregnancy and of carrying a pregnancy to term;
(b) a medical practitioner has offered her the opportunity of referral to appropriate and adequate counselling about matters relating to termination of pregnancy and carrying a pregnancy to term; and
(c) a medical practitioner has informed her that appropriate and adequate counselling with be available to her should she wish it upon termination of pregnancy or after carrying the pregnancy to term.

(6) A reference in subsection (5) to a medical practitioner does not include a reference to —

(a) the medical practitioner who performs the abortion; nor
(b) any medical practitioner who assists in the performance of the abortion.

(7) If at least 20 weeks of the woman’s pregnancy have been completed when the abortion is performed, the performance of the abortion is not justified unless —

(a) 2 medical practitioners who are members of a panel of at least 6 medical practitioners appointed by the Minister for the purposes of this section have agreed that the mother, or the unborn child, has a severe medical condition that, in the clinical judgment of those 2 medical practitioners, justifies the procedure; and
(b) the abortion is performed in a facility approved by the Minister for the purposes of this section.

(8) For the purposes of this section —

(a) subject to subsection (11), a woman who is a dependent minor shall not be regarded as having given informed consent unless a custodial parent of the woman has been informed that the performance of an abortion is being considered and has been given the opportunity to participate in a counselling process and in consultations between the woman and her medical practitioner as to whether the abortion is to be performed.

(b) a woman is a dependent minor if she has not reached the age of 16 years and is being supported by a custodial parent or parents; and

(c) a reference to a parent includes a reference to a legal guardian.
(9) A woman who is a dependent minor may apply to the Children’s Court for an order that a person specified in the application, being a custodial parent of the woman, should not be given the information and opportunity referred to in subsection (8) (a) and the court may, on being satisfied that the application should be granted, make an order in those terms.

(10) An order made under subsection (9) has effect according to its terms and is not liable to be challenged, appealed against, reviewed, quashed or called in question in or by any court.

(11) If the effect of an order under subsection (9) is that no custodial parent of the woman can be given the information and opportunity referred to in subsection (8)(a), subsection (8) does not apply in relation to the woman.

Section 335 – Reports to be furnished

(1) It shall be the duty of every midwife to furnish to the Executive Director, Public Health and to the medical officer of health of the district in which she practices a report in writing in the manner and at the time and in the form prescribed of every case attended by her, whether of living, premature or full-time birth, or stillbirth, or abortion.

(2) A report furnished under subsection (1) shall state the name and address of the mother, and shall be furnished to the Executive Director, Public Health and to the medical officer of health within 48 hours of the event.

(3) A midwife who contravenes subsection (1) as read with subsection (2) commits an offence.

(4) The occupier of any house at which a female not usually resident in any such house, is attended, whether for gain or not, during childbirth or abortion or miscarriage, shall forthwith notify to the medical officer of health that such female is being so attended.

(5) (a) When a medical practitioner attends on the happening of any premature birth, stillbirth or abortion (other than an abortion to which paragraph (d), he shall send to the Executive Director, Public Health within 48 hours of the happening a report in the prescribed form.

(b) A medical practitioner, or where a medical practitioner is not in attendance, a midwife, who attends a woman at the delivery of a foetus at any time after the 20th week of pregnancy shall notify the Executive Director, Public Health of the attendance in the prescribed form.

(c) A medical practitioner who, for the purposes of section 44 of the Births, Deaths and Marriages Registration Act 1998, certifies the cause of a neonatal death shall notify the Executive Director, Public Health of the fact in the prescribed form within 48 hours of the certification.

(d) When a medical practitioner performs an abortion, the medical practitioner shall notify the Executive Director, Public Health of the fact in the prescribed form within 14 days of the abortion being performed.

(e) A notification under paragraph (d) must not contain any particulars from which it may be possible to ascertain the identity of the patient.
(6) (a) The Governor may from time to time proclaim that the provisions of this subsection shall apply in respect of any district or part of a district and may from time to time proclaim that those provisions shall cease to apply in respect of, or having ceased to apply shall again apply in respect of any district or part of a district.

(b) The provisions of this subsection shall apply in respect of a district and part of a district so long as those provisions remain the subject of a proclamation to that effect under the provisions of the last preceding paragraph.

(c) The Executive Director, Public Health shall appoint medical practitioners upon such terms and conditions as he considers fit to conduct a post mortem examination upon the body of every stillborn child where the still birth happens in any district or part of a district to which the provisions of this subsection apply.

(d) The Executive Director, Public Health shall notify in the prescribed manner all medical practitioners and midwives of the name and address of every medical practitioner appointed under the provisions of the last preceding paragraph and acting under the appointment.

(e) When a stillbirth happens in any district or part of a district to which the provisions of this subsection apply, the medical practitioner attending or, if there is no medical practitioner attending, the midwife attending, shall, so soon as reasonably possible after the happening, report it in the manner and form prescribed, to a medical practitioner appointed under paragraph (c) and acting under the appointment, who shall, unless otherwise authorised or directed by the Executive Director, Public Health, thereupon conduct a post mortem examination on the body of the stillborn child.

F. Human Tissue and Transplant Act 1982

Part II – Donations of Tissue by Living Persons

Division 3 – Donations from children

Section 10 – Blood transfusions not subject to this Division

Nothing in this Division prevents the removal in accordance with Division 5 of blood from the body of a child.

Section 11 – References to parents

In this Division, a reference to the parent of a child shall not be read as including a reference to the guardian of a child or to another person standing in loco parentis to the child.

Section 12 – General prohibition of removal of tissue from children

(1) It is not lawful, except as provided by this Part, to remove regenerative tissue from the body of a living child for the purpose of the transplantation of the tissue to the body of another living person.

(2) It is not lawful to remove non-regenerative tissue from the body of a living child for the purpose of the transplantation of the tissue to the body of another living person.
Section 13 – Parent may consent to removal of regenerative tissue from a child
(1) A parent of a child may, in the circumstances specified in subsection (2), consent in writing to the removal from the body of the child of specified regenerative tissue for the purpose of the transplantation of the tissue to the body of another member of the family of the child or to the body of a relative of the child.

(2) The circumstances specified for the purposes of subsection (1) are that—
   (a) medical advice has been furnished to the parent and the child regarding the nature and effect of the removal and the nature of the transplantation;
   (b) the child has the mental capacity to understand the nature and effect of the removal and the nature of the transplantation; and
   (c) the child has agreed to the removal of the regenerative tissue for the purpose of its transplantation to the body of the person referred to in subsection (1).

Section 14 – Revocation of consent
A parent who has given a consent under this Division, or a child who has under this Division agreed to the removal of tissue from his body, may, at any time before the removal of the tissue to which the consent or agreement applies, revoke, either orally or in writing, his consent or agreement, as the case requires, to the removal.

Division 5 – Blood Transfusions
Section 19 – Parent may consent to removal of blood from child
The parent of a child may consent to a removal of blood from the body of the child for a use referred to in section 18 if —
   (a) a medical practitioner advises that the removal should not be prejudicial to the health of the child; and
   (b) the child agrees to the removal.

Section 20 – Consent is sufficient authority for removal of blood
A consent under this Division is sufficient authority for the removal of blood from the body of the person who has given the consent, or from the body of the child of the person who has given the consent, as the case requires.

Section 21 – Blood transfusions upon children without parental consent
(1) A medical practitioner may perform a blood transfusion upon a child without the consent of any person who is legally entitled to authorise the blood transfusion if —
   (a) such person —
      (i) fails or refuses to authorise the blood transfusion when requested to do so; or
      (ii) cannot be found after such search and enquiry as is reasonably practicable in the circumstances of the case; and
(b) the medical practitioner and another medical practitioner agree —
   (i) as to the condition from which the child is suffering;
   (ii) that the blood transfusion is a reasonable and proper treatment for that condition; and
   (iii) that without a blood transfusion the child is likely to die; and

(c) the medical practitioner who performs the blood transfusion on the child —
   (i) has had previous experience in performing blood transfusions; and
   (ii) has, before commencing the transfusion, assured himself that the blood to be transfused is suitable for the child.

(2) When a medical practitioner has performed a blood transfusion on a child without the consent of any person legally entitled to authorise it and in respect of that transfusion the requirements and conditions of this section have been complied with, the transfusion shall be deemed for all purposes to have been performed with the authority of a person legally entitled to authorise it.

(3) Where a medical practitioner other than the medical practitioner who is to perform the blood transfusion on the child cannot be found after search or enquiry for such time as the last-mentioned medical practitioner considers reasonable in the circumstances of the case, having regard to the emergency arising from the condition of the child, it is sufficient compliance with subsection (1) (b) if the last-mentioned practitioner satisfies himself —
   (a) as to the condition from which the child is suffering;
   (b) that a blood transfusion is a reasonable and proper treatment for that condition;
   (c) that to delay the blood transfusion until that other medical practitioner can be found and be available for consultation would cause a serious deterioration in the child’s condition; and
   (d) that without a blood transfusion the child is likely to die.

(4) In this section —
   **blood transfusion** means the transfusion of human blood, any constituent of human blood or saline solution or other liquid, into a child and includes the exchange of the whole or any part of the blood of a child and all medical and surgical procedures necessary to perform the transfusion or exchange; and
   **child** means a person who is or appears to be under the age of 18 years.

(5) Nothing in this section relieves a medical practitioner from liability in respect of the administration of a blood transfusion to a child being a liability to which he would have been subject if the transfusion had been administered with the consent of a parent of the child or a person having authority to consent to the administration of the transfusion.
G. **Civil Liability Act 2002**

Part 1A – Liability for harm caused by the fault of a person

Division 7 – Professional negligence

5PA. **Term used: health professional**

In this Division —

health professional means —

(a) a person registered under the Health Practitioner Regulation National Law (Western Australia) in any of the following health professions —

(i) chiropractic;
(ii) dental;
(iii) medical;
(iv) nursing and midwifery;
(v) optometry;
(vi) osteopathy;
(vii) pharmacy;
(viii) physiotherapy;
(ix) podiatry;
(x) psychology;

or

(b) any of the following —

(i) a medical radiation technologist as defined in the Medical Radiation Technologists Act 2006 section 3;
(ii) an occupational therapist as defined in the Occupational Therapists Act 2005 section 3;
(iii) any other person who practises a discipline or profession in the health area that involves the application of a body of learning.

5PB. **Standard of care for health professionals**

(1) An act or omission of a health professional is not a negligent act or omission if it is in accordance with a practice that, at the time of the act or omission, is widely accepted by the health professional's peers as competent professional practice.

(2) Subsection (1) does not apply to an act or omission of a health professional in relation to informing a person of a risk of injury or death associated with —

(a) the treatment proposed for a patient or a foetus being carried by a pregnant patient; or

(b) a procedure proposed to be conducted for the purpose of diagnosing a condition of a patient or a foetus being carried by a pregnant patient.

(3) Subsection (1) applies even if another practice that is widely accepted by the health professional's peers as competent professional practice differs from or conflicts with the practice in accordance with which the health professional acted or omitted to do something.
(4) Nothing in subsection (1) prevents a health professional from being liable for negligence if the practice in accordance with which the health professional acted or omitted to do something is, in the circumstances of the particular case, so unreasonable that no reasonable health professional in the health professional’s position could have acted or omitted to do something in accordance with that practice.

(5) A practice does not have to be universally accepted as competent professional practice to be considered widely accepted as competent professional practice.

(6) In determining liability for damages for harm caused by the fault of a health professional, the plaintiff always bears the onus of proving, on the balance of probabilities, that the applicable standard of care (whether under this section or any other law) was breached by the defendant.
References

Consent to Treatment Policy for the Western Australian Health System 2011

Superseded by:
OD: 0657/16
Superseded by:
OD: 0657/16

Consent to Treatment Policy for the Western Australian Health System 2011
Delivering a Healthy WA

Superseded by:
OD: 0657/16