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## **Equality, Capacity and Disability in Commonwealth Laws (DP 81)**

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20.05.2014

# **Informed consent to medical treatment**

10.47 At common law, all competent adults can consent to and refuse medical treatment. If consent is not established, there may be legal consequences for health professionals. Under the law of trespass, patients have a right not be subjected to an invasive procedure without consent or other lawful justification, such as an emergency or necessity. At the international level, the CRPD expresses this in terms of a ‘right to respect for his or her physical and mental integrity on an equal basis with others’.<sup>[35]</sup>

10.48 ‘Informed consent’ refers to consent to medical treatment and the requirement to warn of material risk prior to treatment. As part of their duty of care, health

professionals must provide such information as is necessary for the patient to give consent to treatment, including information on all material risks of the proposed treatment. Failure to do so may lead to civil liability for an adverse outcome, even if the treatment itself was not negligent.<sup>[36]</sup>

10.49 The common law recognises that there are circumstances where an individual may not be capable of giving informed consent (for example, due to impaired decision-making ability) or where consent to treatment may not be required, as in the case of emergency. However, except in the case of children—where the High Court has recognised the courts' *parens patriae* jurisdiction in authorising treatment<sup>[37]</sup>—it does not provide significant guidance on supported decision-making in health care settings.

10.50 State and territory guardianship and mental health legislation (discussed below) does provide detailed rules for substitute decision-making concerning the medical treatment of adults who are deemed incapable of giving consent.<sup>[38]</sup>

10.51 Guardianship legislation outlines criteria for appointing substitute decision-makers, the hierarchy of possible decision-makers and the scope of their powers, which depend on the age of the patient and the type of treatment proposed.

10.52 In all jurisdictions, except the Northern Territory, guardianship legislation provides for a decision-maker who is chosen (for example, an enduring guardian), assigned by the legislation (for example, a spouse, close friend or relative) or appointed (for example, by a court) to make health decisions for an adult who is not capable of giving consent.<sup>[39]</sup>

10.53 In exercising their powers, substitute decision-makers are required to adopt one of two tests (or a combination of both in some jurisdictions) in reaching their decision for the person with impaired decision-making capacity. One is the best interests test, which requires a balancing of the benefit to the patient against the risks of the proposed treatment, and the other is the substituted judgment test, which involves making a decision which is consistent with what the person would have decided if they had the capacity to do so. Evidence of such wishes may be provided by advance care directives, religious beliefs and previous history of treatment.<sup>[40]</sup>

## Supported decision-making in health care

10.54 Stakeholders expressed opposition to existing substitute decision-making mechanisms in health care.<sup>[41]</sup> The NCOSS argued for supported decision-making

and stated that ‘quality of life decisions should be made by the affected person’;<sup>[42]</sup> and the Illawarra Forum, stated that ‘every effort should be made to support people to make informed decisions and choices’.<sup>[43]</sup>

10.55 Stakeholders suggested that a supported decision-making framework would be more likely to result in health care decisions that accord with an individual’s personal beliefs and values.<sup>[44]</sup> The Carers Alliance asserted the primacy of the family in supporting people with disability to exercise capacity.<sup>[45]</sup> Family Planning NSW considered that encouraging supported decision-making may help overcome a lack of understanding about what constitutes informed consent in reproductive and sexual health.

*A supported decision making framework needs to encompass the requirement for clinicians, other health and support workers to take on the role of assisting a person to make decisions. This means that they need to develop the skills necessary to talk about reproductive and sexual health in ways that encourage the person to make their own decisions.*<sup>[46]</sup>

10.56 A number of stakeholders expressed concerns about informed consent in the specific context of sterilisation procedures. Women with Disabilities Australia submitted the ‘best interest’ approach to the sterilisation of women and girls has been used in a discriminatory way and the lack of education and accessible services can prevent women from making choices regarding their fertility and conception.<sup>[47]</sup>

10.57 Children with Disability Australia submitted that the criminalisation of forced sterilisation may be justified, as existing requirements for court authorisation have failed to protect the rights of people with disability, under the CRPD, to be free from violence and to retain their physical integrity.<sup>[48]</sup> Several other stakeholders supported legislative prohibition of sterilisation without informed consent.<sup>[49]</sup>

## Review of the law

10.58 The law on decision-making in health care is complex. Inconsistency in language, and different tests of decision-making capacity and processes across the jurisdictions may cause difficulties for health service providers and consumers.

10.59 A number of recent reports have suggested reforms. The VLRC’s guardianship report recommended consolidating existing laws into new legislation distinguishing ‘health decision makers’ from ‘guardians’, and ‘significant’ from ‘routine’ medical

procedures.<sup>[50]</sup> In the context of developing a national code of conduct for unregistered health care workers, the Australian Health Ministers' Advisory Council (AHMAC) has queried whether a national 'minimum enforceable standard' for informed consent should be introduced.<sup>[51]</sup>

10.60 In 2011, AHMAC developed a national policy framework for advance care directives to address challenges posed by divergent laws affecting consent to medical treatment,<sup>[52]</sup> and the ALRC received submissions noting the desirability of nationally consistent and enforceable laws on advance care directives.<sup>[53]</sup>

10.61 The Mental Health Council of Australia and the National Mental Health Consumer and Carer Forum expressed support for a legal framework for assessing health care decision-making ability in line with developments in the United Kingdom under the *Mental Capacity Act 2005* (UK).<sup>[54]</sup> This would place a focus on the ability of people to understand information relevant to a health care decision; retain that information; use or weigh that information as part of a decision-making process; and communicate the decision.<sup>[55]</sup>

10.62 The ALRC proposes that state and territory governments review legislation relating to informed consent to medical treatment, including in relation to advanced care directives, with a view to reform that is consistent with the National Decision-Making Principles and the Commonwealth decision-making model.

10.63 For example, reform encouraging a supported decision-making model might involve recognition that a person may be able to give informed consent to medical treatment with the assistance of a supporter. The implications of such a change, including in relation to the legal liability of health practitioners, would need to be carefully assessed.

10.64 Any new approach to informed consent would need to be reflected in guidance such as the Australian Charter of Rights in Healthcare, the National Safety and Quality Health Service Standards, the National Framework on Advance Care Directives, publications on communication with patients<sup>[56]</sup> and the national codes of conduct of health practitioners.<sup>[57]</sup>

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**[35]** *UN Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008) ART 17.

**[36]** *Rogers v Whitaker* (1992) 175 CLR 479.

- [37] *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218.
- [38] Eg, *Guardianship and Management of Property Act 1991* (ACT) ss 32B, 32D; *Mental Health Act 2009* (SA) ss 56, 57.
- [39] In the NT, there is no provision for consent to medical treatment without an appointment being made. SA has legislation specific to informed consent, which provides for medical powers of attorney: *Consent to Medical Treatment and Palliative Care Act 1995* (SA).
- [40] See, eg, *Hunter and New England Area Health Service v A* [2009] NSWSC 761. The Supreme Court of NSW confirmed a person's advance care directive to refuse medical treatment is valid if it is made by a capable adult, is clear and unambiguous and applies to the situation at hand.
- [41] See, eg, NCOSS, *Submission 26*; The Illawarra Forum, *Submission 19*; Office of the Public Advocate (SA), *Submission 17*.
- [42] NCOSS, *Submission 26*.
- [43] The Illawarra Forum, *Submission 19*.
- [44] Office of the Public Advocate (Qld), *Submission 05*.
- [45] Carers Alliance, *Submission 84*. It was suggested that there is currently insufficient recognition of the role and contribution of carers and family members who possess 'intimate knowledge and understanding of the cognitively impaired person': N Widdowson, *Submission 31*.
- [46] Family Planning NSW, *Submission 04*.
- [47] WWDA, *Submission 58*.
- [48] Children with Disability Australia, *Submission 68*.
- [49] Law Council of Australia, *Submission 83*; Women's Legal Services NSW, *Submission 76*; ADACAS, *Submission 29*.
- [50] Victorian Law Reform Commission, *Guardianship*, Final Report No 24 (2012) recs 12, 199–219, ch 13.
- [51] 'Consultation Paper: A National Code of Conduct for Health Care Workers' (Australian Health Ministers' Advisory Council, March 2014) 16. Most state and territory health departments issue guidelines on consent to health care.
- [52] Australian Health Ministers' Advisory Council, *National Framework for Advance Health Care Directives*, September 2011.

**[53]** Mental Health Coordinating Council, *Submission 07*; ADACAS, *Submission 29*; Law Council of Australia, *Submission 83*.

**[54]** NMHCCF and MHCA, *Submission 81*.

**[55]** See *Mental Capacity Act 2005* (UK) s 3. This approach is reflected in the ALRC's proposed Representative Decision-Making Guidelines: see Ch 3.

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

**[57]** The codes of conduct for the 14 national boards of health practitioners are available at Australian Health Practitioner Regulation Agency, *National Boards* <<http://www.ahpra.gov.au/National-Boards.aspx>>.