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Purpose and Scope

This Professional Standard describes the process of “Informed Consent”.

Background

Informed consent is a process of information exchange, not simply the signing of a consent form. The consent is between a patient of legal competency to provide consent for himself/herself or as a legal guardian of a patient not legally competent to provide consent, and the practitioner.

To do so, they need access to appropriate and readily understandable information about treatment options, risks involved in these treatments, and the expected outcomes. This information should include, but not necessarily be limited to, information concerning the condition, investigation options, treatment options, benefits, possible adverse effects of investigations or treatment, and the likely result if treatment is not undertaken.

The College acknowledges that it is not possible, however, to provide complete information or predict outcomes or assess risks with certainty; and patients need to be aware of this uncertainty.

Body of Professional Standard

1. Members should give information, in a manner that the patient can appreciate, on the possible risks of any intervention.
2. Members should make available, for patients requesting such information, disclosure of training, qualification, accreditation, registration, experience and/or provide avenues for the patient to check such requests independently.



3. Members should, prior to any procedure, provide the patient with an estimate of the fees and charges, and likely total cost of the procedure. Patients should be made aware that further costs could be incurred in the event of possible further treatment or complications occurring. The patient should be responsible to check with relevant health funds or parties including other insurance claims, arrangements for possible reimbursement or rebate on the proposed procedure and related expenses.

4. Members should, before any procedure is agreed to, provide patients with information about:

- how and where the procedure is performed;
- practitioners/registrars assisting in the procedure;
- possible complications and side-effects;
- any anticipated impact on social or occupational activity during recovery;
- the post-operative course and expected recovery time;
- possible alternative treatments where appropriate including the option of no treatment at all;
- the opportunity for 2nd opinion if desired; and
- the usual or expected realistic outcome of the procedure.

5. Members should consult with the patient prior to the procedure, explain the procedure and any associated risks and ensure the opportunity for patients to ask further questions.

6. The patient should have at least one consultation, with the Member performing the procedure before the day of surgery.

For geographical reasons it is sometimes impractical for patients to meet the member face to face for their initial consultation. In these circumstances it is acceptable for the patient, referring practitioner or registrar to send photographs and other appropriate investigations to the member and then a telephone or video consultation with the patient may be arranged.

This can be considered as a consultation with the member performing the procedure. If the patient elects to proceed, the member must see the patient face to face before the procedure, preferably at least one day before. It is accepted that there may be instances where, for logistical reasons, this face-to-face meeting can only occur on the day of surgery, but this should not be considered the norm. If the face-to-face meeting, being the exception, does not occur at least a day before the procedure, the reason for this must be documented.



7. If there is a consultation with someone other than the Member performing the procedure, this is not an acceptable substitute for the process described in points 5 & 6 above, which must still occur.

8. The patient may withdraw consent at any time and should not be coerced or manipulated in any fashion to proceed with any procedure without such consent.

9. Specific issues arise in relation to the obtaining of consent when giving adequate information regarding children, teenagers, the intellectually disabled and those where English is not the first language. Discussion should be with the legal guardian and arrangements should be made for adequate interpreting where language difficulty exists. Language barriers should be dealt with in a bipartisan approach where the patient is also able to adequately express queries and concerns and direct this to the Member through a reliable interpreter.

10. If the patient expressly directs the member to make the decisions and does not want the offered information, the member still has a duty to advise the patient of material risks. Even in this case the doctor should give the patient basic information about the diagnosis and proposed intervention.

11. Whilst informed consent may not necessarily require written confirmation, it is recommended that the consent process has been undertaken, recognised and documented. This is usually undertaken by use of one of a number of "consent forms" which vary from practice to practice and practitioner to practitioner.

Relevant Documents

Royal Australasian College of Surgeons Manual: Division: Subject: Policies and Procedures FELLOWSHIP AND STANDARDS INFORMED CONSENT POLICY Ref. No.: Approval Date: Review Date: Revision No.: Page: FES_PST_2032_P December 2006 December 2008

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