Myths and Facts for Capacity to Consent to Treatment:
Health Care Consent Act, 1996

MYTH: A person's safety and best interest overrides their autonomy

FACT: If a person is capable, they have the right to make their own decision

A person has the right to make their own healthcare decision. If a person wants to make an unsafe and risky decision but understands and appreciates the risks and consequences, then they have the right to make that decision, even if it's contrary to what is being proposed.

The healthcare practitioner's responsibility is to explain the nature, risks, benefits, alternatives and consequences of the plan of care in a manner that is understandable.

MYTH: Incapacity to make a treatment decision is global

FACT: Incapacity to make treatment decisions is not global

A person may be able to decide on a specific treatment being offered by a health practitioner even if they cannot make other treatment decisions.

A person may be capable of consenting at one time but incapable at another time. Catch your person at their "best".

Always presume a person's capacity for a new decision regarding their health care.

MYTH: There is a formal test for evaluating a person's capacity

FACT: There is no formal test for evaluating capacity to consent to treatment

There is no standardised tool to evaluate a person's capacity to consent to treatment. It is based on a conversation with the person to determine if they are able to understand and appreciate information related to the treatment decision.

The health practitioner who is proposing the treatment is responsible for determining if a person has capacity to give or refuse consent.

MYTH: Cognitive testing evaluates a person's capacity to consent to healthcare decisions

FACT: Cognitive testing does not reflect a person's ability to consent to health decisions

A cognitive test measures cognition, not the ability of a person to understand and appreciate the proposed treatment decision.

A person may have the ability to make a specific treatment decision, even when their cognitive abilities are compromised.
The health practitioner provides support to meet the needs of the person to facilitate the consent and capacity conversation.

MYTH: If a person has an identified substitute decision-maker (SDM), they do not have capacity to provide consent to the treatment being proposed

FACT: A person may be capable of providing consent to make a treatment decision even when they have an identified SDM

Even if an SDM has been identified and previously made decisions on behalf of the person, the person may be capable of providing consent for the new treatment being proposed. Evaluate the person's capacity to consent to the proposed treatment.
You must have evidence that the person does not understand and/or appreciate the treatment decision before you approach the SDM.

MYTH: I am not allowed to evaluate capacity to consent to treatment

FACT: All regulated health practitioners can evaluate capacity to consent to treatment

All regulated health practitioners can and are required to evaluate a person's capacity to consent to the practitioner's proposed treatment.

MYTH: You must be an adult to have capacity to consent to treatment
FACT: There is no age criteria for capacity to consent to treatment

Capacity to provide consent is not determined by age. It is determined by whether a person is able to understand and appreciate the proposed treatment.

Therefore, a youth could be capable of providing consent to treatment.

MYTH: A person who has a diagnosis that impacts their decision making does not have capacity to consent to treatment

FACT: All persons are presumed to have capacity to consent to treatment regardless of diagnosis

Some diagnoses may be complex in how they impact a person's ability to function and will vary from person to person. Even if someone has an existing diagnosis that impacts their ability to make some types of decisions (e.g. financial), they may still be capable of providing consent to a specific treatment. Capacity to consent to treatment is decision-based.
Always presume a person is capable to consent to a proposed treatment regardless of any existing diagnosis, such as:

- A psychiatric or neurological diagnosis
- A medical condition (e.g. delirium)
- A disability (e.g. communication, hearing, developmental)