ALFRED HOSPITAL ETHICS COMMITTEE GUIDELINE
OBTAINING TELEPHONE CONSENT FROM THE MEDICAL TREATMENT DECISION MAKER

PURPOSE AND SCOPE

Under the *Medical Treatment Planning & Decisions Act 2016* (Vic), medical research procedures involving adults who do not have decision-making capacity may – *with Ethics Committee approval* – be undertaken with the consent of the medical treatment decision maker (see definition below).

In some situations, it may be difficult for researchers to approach, inform and obtain consent from the medical treatment decision maker *in person*; e.g. where there is limited time before the medical research procedures must commence, or where the medical treatment decision maker is unable to attend the hospital in person.

The following guidelines outline the necessary requirements for the Alfred Hospital Ethics Committee to consider approval of telephone consent by the medical treatment decision maker.

GUIDELINES

1. In all cases, providing information and obtaining consent from the medical treatment decision maker by telephone (rather than face-to-face) has to be regarded as the exception rather than the rule and must be approved in advance by the Ethics Committee as part of the research protocol.

2. The type of research projects for which phone consent may be acceptable are typically 'lower risk' (e.g. comparing routinely used approaches to care) or where the research is of high significance and must commence immediately for it to be effective.

3. The person providing the explanation of the study by phone must be clearly and manifestly capable of conveying the risks and benefits of the research procedure/s involved in a fair and appropriate way. The task cannot be delegated to junior staff with limited knowledge of the details of the research protocol.

4. Phone consent involves an additional onus on researchers to provide complete documentation of the consent process. The documentation should demonstrate that there has been a comprehensive telephone conversation and all significant questions raised have been addressed.

5. The submission to the Ethics Committee requesting approval for telephone consent (for new projects or post-approval amendments) should include a planned process for obtaining phone consent containing the following information:

   a) Planned verbal approach: A guide or script for how the subject of consent would be broached, given that this may be the first instance in which the medical treatment decision maker learns of the patient's admission.

   b) Intention to document:
   The researcher must document in the medical record
   - why the patient was unable to provide consent
   - why a telephone discussion was used
   - who the discussion was with (i.e. names of researcher and medical treatment decision maker)
   - how the medical treatment decision maker was identified (refer to the Medical Treatment Decision Maker Checklist), including any unsuccessful attempts to contact others higher in the list
   - specific issues raised by the medical treatment decision maker in the discussion
   - arrangements for subsequently obtaining signed consent (see below)

   c) Plan to provide written information: The medical treatment decision maker must be given the Information and Consent Form (ICF) and Medical Treatment Decision Maker Checklist to read as soon as is practicable. The researcher should transmit these by fax or email where possible, or, failing that,

two copies* by Express Post or courier. The date on which these were sent should be documented in the medical record. (***one set to be returned and one for the medical treatment decision maker to keep)**

d) Plan for researcher to answer questions: The researcher must provide contact details and be available to answer any additional questions that the medical treatment decision maker may have.

e) Plan to obtain signed consent: The medical treatment decision maker must be asked to sign the consent section of the ICF and the Medical Treatment Decision Maker Checklist.

- The signature section of both should include the date of initial verbal/telephone consent (which may be completed by the researcher before it is posted out) and the date on which the Consent Form was signed.
- The ICF and Checklist may be signed and posted back to the researchers if it is not possible for the medical treatment decision maker to come in to the hospital.
- A photocopy of the signed ICF and Checklist should be included in the medical record and the originals kept with the research files.

6. If signed consent is not received:
Researchers should obtain the signed consent of the medical treatment decision maker wherever possible because it provides additional evidence that consent was given. However, there may be instances when the signed consent is not returned and the medical research procedure has already commenced with phone consent. In such cases, properly documented phone consent (as set out above) would be considered as adequate evidence of the medical treatment decision maker's consent. The researcher explaining the study should make clear to the medical treatment decision maker that if the written consent form is not received and the medical treatment decision maker does not actively revoke their consent, the original phone consent will stand.

DEFINITION OF MEDICAL TREATMENT DECISION MAKER

Section 55, *Medical Treatment Planning & Decisions Act 2016* (Vic)

55 Who is a person's medical treatment decision maker?

(1) If an adult has an appointed medical treatment decision maker, the appointee is the person's medical treatment decision maker if the appointee is reasonably available and willing and able to make the medical treatment decision.

Note

See sections 102(2) and 103.

(2) If subsection (1) does not apply and a guardian appointed by VCAT under the **Guardianship and Administration Act 1986** has the power under that appointment to make medical treatment decisions on behalf of a person, that guardian is the person's medical treatment decision maker if the guardian, in the circumstances, is reasonably available and willing and able to make the medical treatment decision.

(3) If subsections (1) and (2) do not apply, the medical treatment decision maker of an adult is the first of the following persons who is in a close and continuing relationship with the person and who, in the circumstances, is reasonably available and willing and able to make the medical treatment decision—

(a) the spouse or domestic partner of the person;
(b) the primary carer of the person;
(c) the first of the following and, if more than one person fits the description in the subparagraph, the oldest of those persons—
(i) an adult child of the person;
(ii) a parent of the person;
(iii) an adult sibling of the person.

(4) The medical treatment decision maker of a child is the child's parent or guardian or other person with parental responsibility for the child who is reasonably available and willing and able to make the medical treatment decision.

(5) Subsections (1), (2), (3) and (4) do not apply at any time that the person is a mental health patient.

Note
See section 75 of the **Mental Health Act 2014**.

REFERENCES

Medical Treatment Planning & Decisions Act 2016 (Vic)

- The MTP&D Act and a useful Guide and Summary are available from the Department of Health & Human Services website here.

Alfred Hospital Ethics Committee Medical Treatment Decision Maker Checklist

- This Checklist should accompany the Information and Consent Form for the medical treatment decision maker.

Approved by The Alfred Hospital Ethics Committee: 23 October 2008
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