Australian Chiropractic College

INFORMED CONSENT
Policy and Procedure

DEFINITIONS

Terms in this document, for which definitions are not provided in the text or may not be self-evident or for which usage at ACC may differ to that in other higher education institutions are as follows:

AHPRA: Australian Health Practitioner Regulation Agency, which, through the CBA, registers for professional practice, suitably qualified graduates of accredited Chiropractic programs.

Chiropractic Board of Australia (CBA): The statutory body responsible for regulating the chiropractic profession in Australia, including registration standards and public protection, and for appointing the CCEA as the accreditation authority for chiropractic education programs.

Chiropractic Centre: A Service Learning Environment provided by the College, either directly or through a relationship with a third-party authorised by the College, for the provision of chiropractic care by Student Interns under the supervision of Chiropractic Supervisors.

Coercion: Coercion, in the context of informed consent, refers to any conduct that compromises a client's ability to make a free and voluntary decision about their care. It may arise from direct or indirect influence and does not require the use of force or explicit pressure. Coercion includes behaviours such as applying pressure to accept care, repeated requests for agreement after a client has declined or expressed hesitation, presenting information in a manner that is misleading, unduly alarming, or disproportionate to the clinical situation, creating artificial urgency where it is not clinically justified, or structuring communication or care processes in a way that limits the client's genuine opportunity to consider alternatives or decline care. Agreement given under such conditions does not constitute valid informed consent.

Council of Chiropractic Education Australasia (CCEA): The independent accreditation authority appointed by the Chiropractic Board of Australia to accredit and monitor chiropractic education programs, ensuring they meet nationally defined standards for quality, safety, governance, curriculum, resourcing, and graduate competence.

Cultural Safety: Commonly understood as 'an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together' (Williams, R. 1999). Refer to the College's *Cultural Safety Policy and Cultural Safety Procedure.*

Health Privacy: Refers to the ethical and legal obligations governing the collection, use, storage, access, and disclosure of personal and health information within the healthcare context. It encompasses all information arising from the client–practitioner relationship, including clinical records (paper and electronic), health histories, communications, test results, prescribed treatments, and any other identifiable personal data. Health privacy requires practitioners to exercise professional discretion, ensure cultural respect and safety, maintain information security, and obtain informed client consent for access or disclosure to other health practitioners, except where otherwise authorised or required by law. In Australia, health privacy is governed by the Privacy Act 1988 and Privacy Amendment Act 2017, including the Australian Privacy Principles (APPs).

Informed consent: "A person's decision, given voluntarily, to agree to a healthcare treatment, procedure or other intervention that is made, following the provision of accurate and relevant information about the healthcare intervention and alternative options available, and with adequate knowledge and understanding of

the benefits and material risks of the proposed intervention relevant to the person who would be having the treatment, procedure or other intervention." (Australian Commission on Safety and Quality in Health Care, 2022).

Person Responsible/Responsible Person: An individual who is authorised to make healthcare and health-privacy decisions on behalf of a client who lacks decision-making capacity. This includes, where applicable, a parent of a minor client, a legal guardian, or another individual with lawful authority or recognised standing to act on the client's behalf, derived from applicable legislation, court or tribunal appointment, enduring power of attorney, or accepted clinical and ethical decision-making hierarchies. Such authority is exercised only where the client lacks decision-making capacity and no higher-order directive or instruction of which the College is aware applies.

Service Learning Environments (SLEs): An ACC Chiropractic Centre or other Clinical Practicum/WIL Environment where students, under the guidance of Chiropractic or other authorised health professional supervisors develop their knowledge and skills in Chiropractic practice.

Work Integrated Learning (WIL): "any arrangement where students undertake learning in a work context as part of their course requirements. WIL can be undertaken as part of coursework or research training." (Tertiary Education Quality and Standards Agency, 2022) WIL activities may include: professional workplace placements (also known as internships, clinical placements, fieldwork, practicums) whether local, interstate or international, online or virtual WIL (e.g. telehealth) with real clients or industry input, industry-partnered projects in the classroom that involve industry, community or professional partners, a simulated work environment with industry input, consultation or assessment, or activities in other contexts involving industry or community partners.' May also be synonymous with 'Service Learning'.

PURPOSE

This policy and procedure defines informed consent and outlines the requirements and processes for obtaining informed consent in the provision of chiropractic care.

The *Informed Consent Policy and Procedure* is also aligned with the requirements inherent in HESF (2021), specifically:

- 3. Teaching (3.1 Course Design: 3.1.3)
- 5. Institutional Quality Assurance (5.4 Delivery with Other parties: 5.4.1, 5.4.2)
- 6. Governance and Accountability (6.2 Corporate Monitoring and Accountability: 6.2.1 (a); 6.3 Academic Governance: 6.3.1 (a),(c),(d)
- 7. Representation, Information and Information Management (7.2 Information or Current and Prospective Students:7.2.2 (c),(d).

Furthermore, it aligns with the CCEA's *Accreditation Standards for Chiropractic Programs and Competency Standards for Chiropractors* (2025), specifically:

- Standard 1 Public Safety (Criterion 1.2)
- Universal Competency 1 Practising Professionally (1.1, 1.2, 1.4)
- Universal Competency 2 Practising in a culturally safe and respectful way (2.1, 2.2, 2.3)
- Universal competency 3 Communication, collaboration and leadership (3.1, 3.2, 3.3, 3.5)
- Practice Competency 4 Clinical Assessment (4.2)
- Practice Competency 5 Planning Care (5.2, 5.3)
- Practice Competency 6 Implementing, Monitoring and Evaluating Care (6.1, 6.2, 6.3, 6.4).

The ACC requires that all staff (employed or contracted) and students, including those engaged in SLEs/WIL are proactive in establishing, implementing and maintaining informed consent processes in accordance with this Policy and Procedure.

Any breach of the ACC's requirements for compliance with expectations for the informed consent of clients may result in penalties, sanctions or other disciplinary action, in accordance with ACC Code of Conduct and other relevant ACC Policies and Procedures, as listed under *Related Policy Documents* below.

In addition, the ACC requires that all staff (employed or contracted) and students engaged in SLEs and/or WIL are familiar with the concept of Cultural Safety as defined above, and requires that they foster Cultural Safety in all ACC contexts, including the ACC Chiropractic Centres and other SLEs.

SCOPE

This Policy applies to all staff members, contractors and enrolled students. It is applicable in all learning and teaching activities and venues on and off campus, whether scheduled classes or outreach or extra-curricular activities.

POLICY

Principles

The College provides Service Learning Environments (SLEs) for the education and training of chiropractic students. In these environments, the College is responsible for ensuring that chiropractic care provided by students under supervision is safe, ethical, and consistent with professional standards.

In relation to informed consent, the College adopts the following principles:

1. **Client autonomy**
   Clients are entitled to make informed decisions about their care. Consent must be voluntary and free from coercion, and clients may decline or withdraw consent at any time.
2. **Capacity and validity of consent**
   Consent is valid only where the client has the capacity to understand the information provided and to make a decision about the proposed care, or where consent is provided by an authorised substitute decision-maker in accordance with law.
3. **Adequate information**
   Consent must be based on the provision of relevant, accurate, and understandable information about the proposed care, including material risks, expected outcomes, and reasonable alternatives.
4. **Ongoing nature of consent**
   Informed consent is not a single event but an ongoing process. Consent must remain current and is required to be reconsidered where there is a material change in the proposed care or the client's circumstances.
5. **Cultural safety and respect**
   Informed consent processes must be conducted in a manner that is culturally safe, respectful, and responsive to the client's values, beliefs, communication needs, and personal circumstances.
6. **Supervised student practice**
   Where care is provided by students, informed consent must include the client's awareness of student involvement and the supervisory arrangements in place.

Power Asymmetry and Heightened Obligation

The College recognises that the clinical relationship involves an inherent power imbalance. Clients may present in circumstances of pain, concern, or uncertainty, while practitioners hold clinical knowledge, diagnostic authority, and influence over access to care. This asymmetry can affect the extent to which a client's decision is genuinely free and voluntary, even in the absence of explicit pressure.

Accordingly, supervising practitioners and students have a heightened obligation to ensure that consent reflects the client's informed and voluntary choice. This includes communicating in a manner that supports understanding, allowing adequate time for consideration, and ensuring that clients are aware of their right to decline, defer, or discontinue care without pressure or consequence.

Communication

Effective communication is essential to informed consent. The College requires that communication with clients, and where appropriate their families or substitute decision-makers, supports informed decision-making and respects client dignity and autonomy.

In all Service Learning Environments, communication related to informed consent must be:

1. **Clear and understandable**
   Information must be communicated in a manner that is appropriate to the client's level of health literacy, using plain language and avoiding unnecessary technical or professional jargon.
2. **Respectful and professional**
   Communication must be courteous, non-judgemental, and respectful, and must not be coercive, misleading, or dismissive.
3. **Responsive to individual needs**
   Communication must take into account the client's age, maturity, cognitive capacity, cultural background, language needs, and personal circumstances.
4. **Culturally safe**
   Communication must support cultural safety by recognising power imbalances, respecting cultural values and beliefs, and responding appropriately to cultural, linguistic, and communication needs.
5. **Supportive of informed decision-making**
   Clients must be given adequate opportunity to ask questions, seek clarification, and consider information before making decisions about their care.
6. **Consistent with privacy and confidentiality obligations**
   Communication with colleagues and others involved in care must occur within the bounds of applicable privacy, confidentiality, and information-sharing requirements.

Competency to provide informed consent

Informed consent is valid only where the person providing consent has the capacity to do so in relation to the specific decision being made.

The College adopts the following principles:

1. **Decision-specific capacity**
   Capacity to provide informed consent is decision-specific and must be considered in relation to the nature and complexity of the proposed care at the time consent is sought.
2. **Presumption of capacity**
   Clients are presumed to have capacity to provide informed consent unless there are reasonable grounds to consider otherwise.
3. **Supported decision-making**
   Where a client has reduced capacity, reasonable steps must be taken to support the client to understand information and participate in decision-making to the greatest extent possible.
4. **Substitute decision-making**
   Where a client lacks capacity to provide informed consent, consent must be obtained from an authorised substitute decision-maker in accordance with applicable legislation and regulatory requirements.
5. **Minors**
   Where clients are children or young people, consent requirements must be managed in accordance with applicable legislation, taking into account the client's capacity to participate in decision-making and the role of parents, guardians, or other authorised persons.
6. **Supervised student practice**
   In Service Learning Environments, supervising practitioners are responsible for ensuring that informed

consent is obtained in accordance with this policy and that students act within the limits of their competence and authority.

INFORMED CONSENT PROCEDURE

1. Purpose of the Procedure

This procedure sets out the steps required to obtain, maintain, document, and review informed consent for chiropractic care provided within ACC Chiropractic Centres and other approved Service Learning Environments (SLEs).

2. Scope

This procedure applies to:

- supervising chiropractors and other authorised supervising health professionals;
- ACC-employed or contracted staff involved in clinical care;
- enrolled students providing care under supervision in SLEs.

3. Responsibility

- **Supervising practitioners** are responsible for ensuring that informed consent is obtained and remains valid.
- **Students** may participate in consent discussions only under supervision and within the limits of their competence.
- **The College** is responsible for ensuring appropriate systems, training, and oversight are in place.

4. When Informed Consent Must Be Obtained

Informed consent must be obtained:

1. Before any clinical examination, investigation, or care is commenced.
2. Before a new or materially different care or management approach is introduced.
3. When there is a significant change in the client's health status or circumstances.
4. When a new presenting complaint arises.
5. When students are involved in care and this involvement has not previously been disclosed.

Consent must be reaffirmed periodically during ongoing care.

5. Information to Be Provided to the Client

The supervising practitioner must ensure that the client (or Responsible Person) is informed of:

- a working diagnosis or clinical impression, identifying what is most likely wrong, the basis for that view;
- the nature and purpose of the proposed examination or care;
- the expected benefits and likely outcomes (prognosis);
- material risks and possible complications;
- reasonable alternatives, including the option of no care;
- any relevant financial costs;
- the involvement of students and the supervision arrangements in place.

Information must be communicated in plain language in a manner that is understandable to the client and appropriate to their needs.

6. Communication Requirements

When obtaining informed consent, communication must:

- use plain language and avoid unnecessary technical terms;
- allow sufficient time for questions and consideration;

- take into account health literacy, language needs, cultural context, age, and capacity;
- support culturally safe and respectful interactions;
- avoid coercion, pressure, or misrepresentation.

Where required, reasonable steps must be taken to support communication needs, including the use of interpreters or other communication supports.

7. Assessing Capacity to Consent

The supervising practitioner must consider whether the client has the capacity to provide informed consent for the specific decision at the time consent is sought.

Capacity assessment must consider whether the client can:

- understand relevant information;
- retain that information long enough to make a decision;
- use or weigh the information to make a decision; and
- communicate their decision.

Capacity is **decision-specific and time-specific**.

8. Children and Young People

- Clients aged **16 years and over** are presumed to have capacity to consent unless there are reasonable grounds to consider otherwise.
- For clients **under 16 years of age**, informed consent must be obtained from a parent, guardian, or other authorised responsible person.
- Where appropriate, the client should be involved in the decision-making process to the extent of their capacity.

9. Clients Without Capacity

Where a client lacks capacity to provide informed consent:

- consent must be obtained from a Responsible Person in accordance with applicable legislation;
- supported decision-making must be used where possible to involve the client;
- emergency care may proceed only in circumstances permitted by law.

10. Form of Consent

Informed consent may be obtained verbally or in writing, depending on the level of risk, complexity, and clinical significance of the proposed examination or care.

1. **Implied consent**
   May be relied upon only for low-risk, routine interactions that a reasonable person would expect as part of a general examination and that do not involve material risk or symptom provocation.
2. **Verbal informed consent**
   Must be obtained for examinations and procedures that involve clinical decision-making, potential discomfort, or low to moderate risk.
   Verbal consent must be supported by appropriate clinical explanation and **documented in the clinical record**.
3. **Written informed consent**
   Must be obtained where:
   - the procedure carries higher or material risk;
   - there is a risk of significant adverse outcome;
   - the proposed care involves ongoing treatment planning (e.g. care plans following ROF);

- required by law or organisational policy; or
- the supervising practitioner determines it is clinically or ethically appropriate.

Where there is uncertainty regarding the appropriate form of consent, **written consent should be obtained**.

10.1 Implied Consent – Further Clarification

Implied consent may be recognised only in limited circumstances where a client's actions clearly indicate agreement to a low-risk, routine interaction that a reasonable person would expect as part of a general examination, and where no material risk, discomfort, or decision regarding care is involved.

Implied consent must not be relied upon where:

- the interaction carries more than negligible risk;
- the interaction may provoke pain, discomfort, or symptom aggravation;
- the interaction forms part of a diagnostic or treatment decision; or
- a reasonable person in the client's position would expect to receive information about risks, benefits, or alternatives before agreeing.

In all such circumstances, **express informed consent must be obtained**, either verbally or in writing.

Silence, lack of objection, or passive compliance must not be interpreted as consent.

11. Documentation

The supervising practitioner must ensure that the clinical record includes:

- confirmation that informed consent was obtained;
- a summary of the information provided to the client;
- any questions asked by the client and responses given;
- any limitations, conditions, or withdrawal of consent.

Records must be accurate, contemporaneous, and accessible in accordance with privacy and records management requirements.

12. Withdrawal of Consent

- Clients may withdraw consent at any time.
- Withdrawal of consent must be respected immediately.
- Any withdrawal and subsequent actions taken must be documented in the clinical record.

13. Review and Monitoring

- Compliance with this procedure is monitored through supervision, clinical audits, and quality assurance processes.
- Any identified issues or breaches must be managed in accordance with ACC governance, risk, and disciplinary frameworks.

14. Use of Clinical Measurement Devices and Outcome Measures

14.1 General Principle

Where clinical measurement devices or outcome measures are used, they must support - and not replace - the informed consent process. The use of such tools does not in itself constitute provision of adequate information.

14.2 Communication Requirements

The supervising practitioner must ensure that, in a manner appropriate to the context, the client understands:

- the general purpose of the tool (e.g. assessment, baseline, or monitoring);
- the nature of the information it provides; and
- any material limitations relevant to how the result is interpreted or used in clinical decision-making.

This information must be proportionate to the significance of the tool in informing the care recommendation.

14.3 Appropriate Use

Clinical measurement devices and outcome measures must not be used in a manner that:

- misrepresents the significance of findings;
- presents results in a way that is misleading or unduly alarming;
- attributes diagnostic or clinical meaning beyond the supported scope of the tool; or
- is used primarily to influence agreement to care rather than to inform clinical reasoning.

14.4 Outcome Measures

The use of validated outcome measures (e.g. pain scales, functional indices) to establish baseline status and monitor response to care is appropriate and supports informed decision-making where used consistently and interpreted within their validated scope.

14.5 Documentation

Where a clinical measurement device or outcome measure is used to support, justify, or influence a clinical recommendation or care plan, the clinical record must include:

- the tool used and its general purpose; and
- the role of the result in the clinical assessment or care recommendation.

Routine use of validated outcome measures for baseline assessment or ongoing monitoring (e.g. standardised pain or functional scales) does not require additional documentation beyond normal clinical recording, unless the result is used to inform a specific clinical decision or recommendation.

IMPLEMENTATION and MONITORING

The implementation of this policy and procedure is the responsibility of the Program Coordinator – Chiropractic Practice, under delegated authority from the Academic Dean.

The Program Coordinator – Chiropractic Practice will report quality assurance, compliance or other issues that arise to the Academic Dean. The Academic Dean shall, through end of semester reports, report such data to the Academic Board as part of the Quality Assurance Cycle.

The Program Coordinator – Chiropractic Practice will also ensure that any breaches of this Policy and Procedure are notified to the CEO, Academic Dean and President. The CEO will ensure that all potential risks in maintaining appropriate processes for informed consent are notified to both the Academic Board and the Finance, Audit and Risk Committee, for consideration and recommendation to the Board of Directors.

RELATED POLICY DOCUMENTS

- Health Privacy Policy and Procedures
- Care of Children Policy and Procedures
- Cultural Safety Policy
- Cultural Safety Procedure
- WIL/Clinical Practicum Framework
- WIL/Clinical Practicum Policy
- WIL/Clinical Practicum Procedure
- Assessment of Coursework Policy
- Staff Induction and Professional Development Policy and Procedures
- Secure Information Management Policy and Procedures
- Records Management Policy
- Code of Conduct Policy and Procedures
- Grievance Management Non-Academic (Students) Policy and Procedures
- Grievance Management (Staff) Policy and Procedures

REVIEW

The ACC's Informed Consent Policy and Procedures is reviewed every three years.

It is a policy of the ACC that any Policy or Procedure may be reviewed earlier as indicated by internal or external factors (including but not limited to such factors as changes in the guidelines of regulatory authorities, accreditation/registration requirements of the profession, or relevant legislation at state or federal level) as determined the Board of Directors and/or Academic Board.

RELATED LEGISLATION, REGULATORY REQUIREMENTS and REFERENCES

- ACA Code of Ethics https://www.chiro.org.au/wp-content/uploads/2019/12/ACA-code-of-ethics2017.pdf
- *Advance Care Directive Act 2013 (SA)* Published under the *Legislation Revision and Publication Act 2002*
- **AHPRA** (Chiropractic Board), June 2022, *Shared - Code of Conduct*.
- Australian Commission on Safety and Quality in Health Care, 2020, *Informed Consent in Health Care, Fact Sheet for Clinicians* – accessed on-line Dec 2022 at https://www.safetyandquality.gov.au/sites/default/files/2020-09/sq20-030_-_fact_sheet_-_informed_consent_-_nsqhs-8.9a.pdf
- Australian Commission on Safety and Quality in Health Care, 2022, *Partnering with Consumers – Informed Consent* - accessed on-line Dec 2022 at https://www.safetyandquality.gov.au/our-work/partnering-consumers/informed-consent
- *Children and Young People (Safety) Act* 2017 (SA)
- *Consent to Medical Treatment and Health Care Policy Guideline 2014* (SA)
- *Consent to Medical Treatment and Palliative Care Act 1995* (SA) referred to as the *Consent Act 1995 (SA) and Changes legislated in July 2014*
- *Human Rights and Children and Young People (Australian Human Rights Commission (current) https://humanrights.gov.au/sites/default/files/content/letstalkaboutrights/downloads/HRA_young.pdf*
- *Law Handbook* SA, 2018
- *Mental Health Act 2009 (SA)*

VERSION CONTROL

Document: A0021 Informed Consent Policy and Procedure	
Responsible Officer: Academic Dean	
Initially endorsed by: Academic Board	**Date:** 25 January 2023
Reviewed and Approved by: Academic Board	**Date:** 6 May 2026

HESF	1.4 Learning Outcomes and Assessment	1.4.2b 1.4.2c
Version: V2	**Replaces Version(s)**: V1	**Next Review:** January 2029
Nature of change	**May 2026:** Comprehensive review and restructure of the Informed Consent Policy and Procedure to align with updated CCEA Accreditation Standards and Competency Standards (2025), contemporary governance expectations, and current legal and ethical standards relating to informed consent. Revisions strengthen definitions and principles relating to coercion, power imbalance, communication, cultural safety, capacity, substitute decision-making, and supervised student practice; clarify requirements for verbal, written, and implied consent; expand guidance regarding documentation, withdrawal of consent, and use of clinical measurement devices and outcome measures; and update governance, reporting, and implementation responsibilities.	