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Dear Ms Sinclair

Revision of the NSW Health Policy Directive “Consent to Medical Treatment – Patient Information”

We refer to your recent letter to Professor Simon Willcock requesting our comments on the revised draft Consent Manual. Thank you for the opportunity to provide input into this document.

We have provided comments in the format requested and our comments are attached.

The draft Consent Manual is a comprehensive document setting out the law of consent in New South Wales. It covers many of the areas about which we receive requests for advice and assistance from our members. This Manual will be useful to our members and to us when dealing with clinical situations in which clarification is needed about the application of the law of consent.

Being a comprehensive and consequently lengthy document, it would be worthwhile including an executive summary of one to two pages or a flow chart outlining the key points. This could be a good way of pointing out the key concepts and resources to which a doctor could quickly refer when faced with a difficult clinical scenario in practice.

Please contact me on the details below if you require any further information or clarification of any of our comments.

Yours sincerely

A handwritten signature in blue ink, appearing to read "Georgie", with a long horizontal flourish extending to the right.

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Head of Advocacy

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NSW Ministry of Health, Legal & Regulatory Services – Comment Template

DOCUMENT TITLE:	Consent Manual
DOCUMENT NO:	V1
CLOSING DATE:	15.12.14
ENQUIRIES	Blaise Lyons, Principle Legal Officer, telephone: 9391 9612, email: blyon@doh.health.nsw.gov.au Louise Sinclair, Senior Legal Officer, telephone: 9424 5781, email: lsinc@doh.health.nsw.gov.au
COMMENTS PROVIDED BY:	Avant Mutual Group
General Comments:	<ul style="list-style-type: none"> • To improve readability, we suggest replacing “prior to” with “before”, and removing “in order..” from “in order to” throughout the document • Amend sections relating to Mental Health Act as amendment bill has now been passed • The document is very comprehensive, but this means it is also long and may not be read in detail by busy practitioners. We suggest that you provide a summary and / or a flow chart at the beginning of the document outlining the key points.

Specific Comments

Section/Page Number	Comment	Suggested Inclusion / Text / Amendments / Other
1.1 page 4	<p>Typographical error “Principless”</p> <p>9th dot point commencing “Information provided...”</p>	<p>Replace with “Principles”</p> <p>Suggest adding “...and needs to be clear and easy to understand”</p>
1.2 page 7	<p>Incorrect spelling of “practise” (US rather than Australian spelling used) in definition of “medical practitioner”</p> <p>Definition of “Person responsible”</p>	<p>Replace “practice” with “practise”</p> <p>The use of the word “next” before Person Responsible does not appear necessary.</p>
1.2 page 8	Definition of “Power of Attorney”	Suggest add in a comment as to whether Powers of Attorney made in different jurisdictions are valid in NSW.
2.2.1 page 12	Emergency treatment – adults	Suggest adding in the word “known” in the sentence “...provided that there is no known unequivocal written direction by the patient to the contrary”
2.2.2 page 12 and 2.3.1 page 13	Patients who lack capacity - minors	Suggest adding in the word “fully” after understand, to reflect the Gillick test and to be consistent with the wording in 6.3.
2.3.4 page 14	We suggest re-wording the sentence “The mere mechanical signing of a consent form is, of itself, of limited value”. It is slightly inconsistent with the message conveyed in 2.8 (page 23) that a consent form is “...important in protecting the hospital and attending medical practitioner from certain legal liabilities”.	<p>Suggest amending the wording to read:</p> <p><i>The signing of a consent form may of itself be of limited value if the requirements for obtaining a valid consent as outlined above are not met.</i></p>
2.4 page 16	Patient consent forms and health care records – this paragraph is a bit confusing. It is stated in the first sentence that the consent form should be a “stand alone” form in the patient’s health record, but in the last sentence it says that if the consent form is part of an admission booklet the relevant sections must not be separated. This	Suggest setting out in point form the different ways in consent forms can be generated and how those forms are to be kept in the health record.

	makes it hard for the consent form to be a “stand alone” document in the health record.	
2.5 page 17	<p>In answer to the Consultation question, we do not believe it is necessary to include a page discussing recent developments in the law of consent for the purposes of this document. It is sufficient in our view to have the basic principle in Rogers v Whitaker outlined here.</p> <p>It may be useful to include some techniques to ascertain what risks are material to a patient, such as: Take time to know the patient and understand what is important to them; Use open ended questioning techniques to ascertain patient understanding of the treatment options and risks. Some sample questions could be provided in the proposed communication aids referred to on pg 20</p> <p>The final sentence on page 17 is reminiscent of the doctrine of therapeutic privilege. It may be appropriate to include a cross reference to the discussion on therapeutic privilege on page 21.</p>	<p>Suggest adding in this section words to the following effect:</p> <p><i>This is a patient-centred test; it is not the practitioner who decides what should or should not be disclosed. The medical practitioner has an obligation to explore this with the patient and to provide the patient with relevant information whether the practitioner considers it significant or not.</i></p> <p><i>To do this, the medical practitioner should check the patient’s understanding of the proposed procedure/treatment by asking open questions such as questions beginning with “How do you think ” and ‘What do you understand’ . Through this process the medical practitioner will usually gain an understanding of what risks are material to a patient.</i></p> <p>Suggest adding a sentence:</p> <p><i>In extremely limited circumstances information about risks can be withheld on the grounds of therapeutic privilege: see section 2.6</i></p>
2.5 page 19		Suggest including a sentence “If an information sheet or brochure is given to the patient this should be documented in the patient’s record.”
2.5.2 page 19 par 2	Missing word	Should read “The medical practitioner should assist the patient to understand the material <u>risks</u> ..”
2.5.2 page 19 par 4	Material risk is subjective and may be person specific and therefore, patient information cannot disclose all ‘ <i>material risks</i> ’.	Suggest replacing “ <i>material risk</i> ” with “ <i>all known risks</i> ”

2.6 page 21	If information is withheld on the grounds of therapeutic privilege this should be documented in the medical record	Include a sentence to the effect that if information is withheld on the grounds of therapeutic privilege this should be documented in the medical record and the basis upon which the information is withheld
3.4 page 28	Use of the word “shall” at the bottom of the page	Change to “should” or “must” as appropriate
3.5 page 29 and 3.6 page 30	Use of the “other” next to “nurses” in the heading. Role of nurses in obtaining consent and / or providing information to patients	Suggest removing the word “other” as the section deals with the ability of any nurses obtaining consent, not “other nurses”. Suggest clarifying in 3.5 and 3.6 what information can be provided to patients by nurses. In 3.5 it says that nursing staff cannot be delegated the task of informing patients about the material risks of a procedure. However, in 3.6 it contemplates that nurses (health practitioners) will provide “...additional advice” to patients that needs to be recorded in the health record.
4.2.1 page 33	While in A’s case the court decided that it was not (legally) necessary for the person giving it to be informed of the consequences of deciding in advance to refuse treatment, it is good clinical practice to do so. There is no reference to the validity of ACDs or similar documents made interstate.	Suggest adding some words to this effect in this section Suggest adding a paragraph dealing with ACDs or equivalents made interstate
4.2.4 page 34 par 4	Typographical error so it currently reads “In cases wherelegal ...”	Add space between “where” and “legal”
4.2.5 page 34	Answer to Consultation question – we agree that there should be a reference to the document about advance care planning and end of life decisions for people with a mental illness	
4.3 page 35	Answer to Consultation question – we agree that it would be helpful to include practical examples of circumstances where patients elect to be discharged against medical advice.	Suggest also adding in advice about patients who insist on being discharged, following day surgery, without an accompanying person to take them home.

4.4 page 36	The phrase that a court may be prepared to “...qualify a competent woman’s right to refuse treatment...” needs some elaboration.	Suggest providing an example of when or how a court may “qualify” a woman’s right to refuse treatment. It is often the case that a woman refuses treatment in the middle of the night. Suggest adding in where/how the medical practitioners obtain advice after-hours from the hospital and/or Ministry of Health as appropriate
5 page 38	Answer to Consultation question – from our experience providing advice to members, the issues surrounding consent and patients who lack capacity is a difficulty in practice. It would be helpful to include a flow chart to assist.	
5.1 page 38		Suggest replace “competency” with “capacity” for consistency
5.4 page 40	Although in this section it is implicit that the patient lacks capacity to make a decision, if this section is read on its own it may be confusing without referring to this	Suggest an addition to the first sentence so it reads “... objections to treatment (even though the patient lacks decision-making capacity)”
6.2 page 42	References only to parents not guardians	Suggest amending to read “..parents or guardians” to be consistent with 6.3.
6.3 page 43	On pages 44 and 48 the term “mature minor” is used, but it is not referred to in this section.	Suggest refer to the term “ mature minor” in words to the following effect: <i>A patient who is Gillick competent is also referred to as a “mature minor”</i> Suggest adding words to the effect that it is “advisable to document that the patient has been assessed as having sufficient maturity to fully understand what is proposed”.
6.3 page 44 table	The guide in the table is confusing especially in relation to ages 14 and 15. If a child is Gillick competent, consent of a parent is not required legally.	Suggest amending the recommendation to: <i>Consent of the young person will be sufficient if the young person is Gillick competent. If a young person is Gillick competent, consent of the parent or guardian is not legally</i>

		<i>required but the young person should be encouraged to involve their parent or guardian in the decision-making process.</i>
6.6 page 46	<p>This paragraph may imply that it is acceptable to assume that a stranger has been delegated responsibility for a child.</p> <p>Use of the phrases “...but bears some relationship to the child” and “reasonable to assume the parent or guardian has delegated responsibility to that person”, is unclear and potentially confusing.</p>	<p>Suggest adding some examples to clarify eg family members; close friends. Suggest that adding that if there is any doubt contact should be made with the child’s parent or guardian to confirm and documented in the child’s health record</p> <p>Suggest clarifying the wording of this paragraph to make it clearer. There is a risk that if this advice is followed that the parents could make a complaint about the hospital / medical practitioners for failing to obtain their consent.</p>
6.8 page 48	The advice in this section needs to be more direct.	<p>Suggest clarifying the phrase “...not necessarily legally binding”</p> <p>Suggest elaborating and clarifying the status of ACDs for mature minors.</p> <p>It may be useful to provide examples of</p>
7.2 page 53		Suggest including a cross reference to section 4.4 relating to pregnant patients
7.3 page 54		Suggest adding a reference to obtaining consent to anaesthetic treatment where there is a known ACD (cross reference to the section on ACDs).
7.5 page 56	Paragraph 9 refers to the NSW Health Policy Directive PD2005_341	Does this need to be amended to include reference to Policy Directive 2013_051 (17 December 2013)?
7.8 page 60	7.8.1 deals with how to manage the situation where a patient will not consent to disclosure of genetic information, but there is no equivalent section on how to manage a refusal to disclose HIV status.	In our experience, members are troubled about their legal and ethical obligations where patients indicate they have not and will not disclose their HIV status to partners etc. Suggest adding in a section dealing with this issue as it relates to obtaining consent or overriding a patient’s consent (as in 7.8.1).
7.10 page 63	The first paragraph states that where refusal of treatment may lead to the death of the patient the refusal “must” be	Suggest amending so the sentence reads:

	<p>in writing. This may not always be possible practically.</p> <p>There are some typographical errors:</p> <ul style="list-style-type: none"> • paragraph 1: no space between “writing” and “and” • Advance care directives is in a smaller font <p>Although it is stated (correctly in our view) in paragraph 4 that “other Persons Responsible do not have the express power to consent to withholding or withdrawing treatment, the paragraph does suggest that persons responsible cannot consent to withholding and withdrawing treatment. In the case of <i>BAH</i> [2007] NSWGT 1 (5 February 2007), the Tribunal stated:</p> <p>“[52] ... in accordance with Part 5 of the Act, consent can be given (or refused) for medical treatment, which includes palliative care. Palliative care, as defined above, can include treatment limitations, such as the non-provision of treatment. Accordingly under Part 5, requests or applications to a substitute consent giver for consent to treatment limitations can be made in relation to palliative care.</p>	<p><i>“... where refusal of treatment may lead to the death of the patient, the refusal should be in writing and signed by the patient. The refusal must always be documented.”</i></p> <p>Suggest amending the paragraph to make it clear that persons responsible can make treatment decisions that include limitations of treatment at the end of life.</p>
8 page 65	The table refers to consent to release of documents but this is the first time it has been referred to	Consider whether to include a section earlier in the manual about consent to the release of documents