Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Right 7(4)and Necessity

"This is not my home"

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What obtaining informed consent means in practice

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- A **competent** person…
- Making a **voluntary** choice…
- About **information** communicated effectively…
- Which is **sufficient** to make an informed decision

A competent person…

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- Every person is **presumed competent** unless there are reasonable grounds for believing that the person is not competent (Right 7(2))
- Determining competence:

  - Clinical assessment

  - Legal test – whether person understands the nature, purpose, effects and likely consequences of the proposed treatment or of refusing treatment

A competent person…

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Where a person has diminished competence, that person retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence (Right 7(3))

When a person can not give consent

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- Emergency Situations (Necessity)
- Right 7(4)
- Advance Directives (Right 7(5), clause 4)
- Court Orders
- Enduring Powers of Attorney/Welfare Guardians (PPPR Act)

Necessity

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- General view-justified in emergency to proceed without consent if consent cannot be obtained and not previously refused
- Must be necessary to preserve life, health and well being and in the best interests of the person

Necessity

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- e.g- unconscious accident victim, or unforeseen finding during surgery needing immediate response
- If not- wake patient up See HPDT decision Med09/113D
- Clause 3 –defence if provider has taken reasonable actions in the circumstances

Necessity

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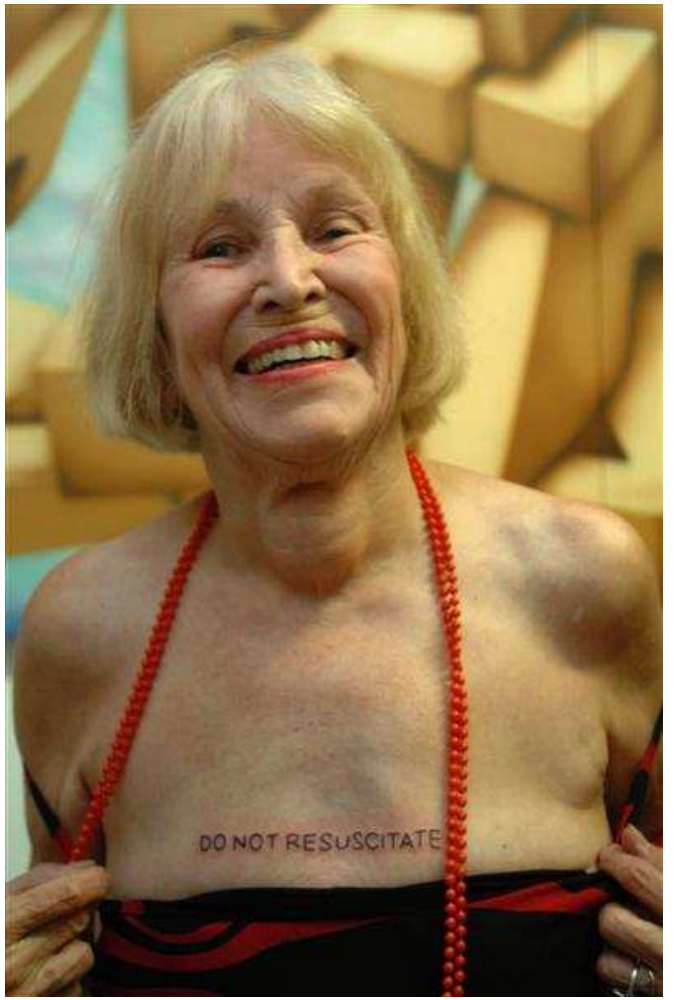
However, the treatment:

- Is not justified if contrary to the known wishes of a competent person
- must not be inconsistent with a valid Advance Directive
- must be, and be no more than, what a reasonable person would expect to receive in all the circumstances



Right 7(4) of the Code of Rights

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Clinician can provide treatment if:

- Person is **not competent** to make an informed choice;
  AND
- There is **no one else entitled to consent** on their behalf;
  AND treatment is in person's **best interests**;
  AND EITHER
  - Reasonable steps taken to ascertain **person's views** and treatment is in accord with what person would have chosen; **OR**
  - **Views of other suitable persons** are taken into account

Right 7(4)

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- Right 7(4) 'emergency' exception to informed consent principles, permitting 'best interests' treatment where consumer is not competent to consent, no legal 'proxy' is available and, time permitting, any 'significant others' or family have been consulted
- Right 7(4) means that, even when consumer not competent to consent, providers must take reasonable steps to find out what consumer would want to happen, and act accordingly

Right 7(4)

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- Consumer's wishes still important even when no longer competent
- What if consumer refuses treatment/ wants to leave?
- Right 7(4) not a licence to act when court order could reasonably be sought

08HDC20957

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"[The rest home] argued that it was acting under the doctrine of necessity in order to preserve Ms R's life or health. I do not accept that a situation of emergency existed during the 14 months of Ms R's stay at [the rest home]. At most, it may have been appropriate to treat her for the first few days after her admission while clarifying the position with regard to the Court order and/or the existence of an enduring power of attorney."

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"[The rest home] too, had a responsibility to verify Ms R's legal status, and to be clear about the legal basis on which it was to provide services. While this is important for all health and disability service providers, the fact that [the rest home] is a secure facility with the ability to physically detain people, and it routinely provides services to people with diminished capacity, means it should have been particularly vigilant."

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"I note also that if, at the time of Ms R's admission, [the rest home] provided services on the understanding that she was unable to give informed consent herself, insufficient consideration was again given to the implications of this. Surely, any provider in this situation would immediately ask: who can consent on this person's behalf and who should we therefore be communicating and consulting with?"

Case Study 13HDC01252

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- In 2006, Mrs G (then aged 80) appointed her daughter to be her EPOA for personal care and welfare
- Not activated via medical certification of incompetence
- Complex medical history including dementia
- 2012- recent fall and was confused
- Admitted to hospital- GP suggested pneumonia
- X-ray showed no evidence of pneumonia, and general physician thought she might have a UTI

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- Behaviour disrupting the ward - thought to have delirium in addition to cognitive impairment
- Prescribed low dose (0.5mg) haloperidol (an antipsychotic), to be administered 2-hourly PRN
- Competence not assessed
- No evidence of any discussion with Mrs G and/or daughter about options for treatment, or risks, side effects, and benefits of haloperidol
- No consent obtained for administration of haloperidol

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- Mrs G discharged - GP stopped haloperidol 2 weeks later
- Prior to hospital admission, Mrs G able to walk well without an aid
- Following discharge - shuffled, taking small steps, and unable to get in and out of bed by herself
- Facial expression blank
- Daughter felt haloperidol was a major contributor to mother's deterioration

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- Readmitted -had not managed at home and severe falls risk
- Daughter requested that haloperidol not be administered to her mother
- Was administered 5 times in 4 days when Mrs G agitated and non-compliant with cares
- Again no consent was obtained for administration of haloperidol
- Haloperidol then stopped and Mrs G administered low dose quetiapine (alternative antipsychotic)

You be the Deputy Commissioner

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You be the Deputy Commissioner

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- Should the EPOA been activated?
- Should the daughter's consent been obtained?
- On what legal basis could haloperidol have been commenced?
- What about the second admission?

Analysis

“The level of competence required to make a decision may depend on the nature of that decision. There are not always clear lines between states of competence and incompetence, particularly in cases like Mrs G’s, and a consumer’s competence may vary from time to time.”

Analysis

"The issue in this case is whether there were reasonable grounds to believe that Mrs G was not competent to consent to the administration of haloperidol, at the time it was administered to her. If there were not reasonable grounds to rebut the presumption of competence, then Mrs G should have given consent to her treatment herself. There is no evidence that Mrs G's consent to the administration of haloperidol was sought or obtained from her when the drug was administered to her... "

Analysis

"[Daughter] was clearly a suitable person who was interested in her mother's welfare and was available to advise the clinicians and, accordingly, if treatment of Mrs G with haloperidol was to be provided pursuant to Right 7(4) of the Code, [her daughter] should have been consulted first, and her views should have been carefully considered."

Findings

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- DHB clinicians not clear as to the legal basis on which haloperidol was administered to Mrs G during both admissions -by consent from Mrs G or within the terms of Right 7(4)?
- DHB breached Right 7(1) of the Code

Findings

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- Use of haloperidol during second admission - clinically unwise
- In light of earlier reaction and daughter's concerns issue of cessation of the haloperidol should have been considered earlier during second admission

Final comments

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- All adults have the same rights to individual autonomy and to decide what happens to them and their bodies, regardless of age
- Where they are no longer able to make those decisions themselves, they still have the right to be treated with respect and dignity
- Do all incompetent residents have someone to advocate/complain on their behalf?
- Does the existing law provide sufficient protection of rights?

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