RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

Royal Australasian College of Physicians' submission to the Medical Council of New Zealand

Draft statement on Information, choice of treatment and informed consent
June 2019

Introduction

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to submit feedback on the Medical Council of New Zealand's (Council) updated statement on Information, Choice of Treatment and Informed Consent (the Statement).

The RACP works across more than 40 medical specialties to educate, innovate and advocate for excellence in health and medical care. Working with our senior members, the RACP trains the next generation of specialists, while playing a lead role in developing world best practice models of care. We also draw on the skills of our members, to develop policies that promote a healthier society. By working together, our members advance the interest of our profession, our patients and the broader community.

Key points

- The RACP supports the intention of the revised statement, and welcomes new sections which have been included for currency
- We have recommended several amendments for clarity.

RACP responses to Council's questions

1. Are there any other key points that should be included or omitted in from the summary box?

The RACP suggests the following amendment to the third bullet point in the summary box, so it would read:

- Under the Code of Health and Disability Services Consumers Rights (the Code), every patient has the right to make an informed choice, and to give informed consent except if the patient is not competent to do so, *in which case the patient retains the right to make choices and give consent to the extent appropriate to their level of competence*.

The amendment suggested covers Right 7(3) of the Code, which relates to situations where patients have diminished competence.

2. In your view, are there any other points that should be covered in 'Background'?

We welcome the references in the Background section to working in partnership with the patient, their whānau and caregivers.

In the second paragraph, we suggest Council amends the first sentence to read "… their condition and how that *can* be managed", and the phrase "*to the extent that they are willing and able to*" should be inserted at the end of this paragraph, following "… decisions about their care".

The Background section notes the foundational importance of trust to the doctor-patient relationship, which in turn supports patients being able to make an informed choice about their medical treatment and management. The Statement does not elucidate the power (and specialist medical knowledge) imbalance between a doctor and a patient. Given this imbalance, there is a greater risk of a patient becoming stressed or anxious if diagnoses, treatment and management options are not explained in a manner the patient can understand, and longer-term implications may not be realised by the patient or their whānau at the time of the doctor-patient encounter.

It may be beneficial to state upfront in a section such as the Background that a power imbalance exists between doctor and patient. Where possible, doctors should offer patients, whānau and caregivers the opportunity to take additional time prior to making a decision, or seek a second opinion if they wish.

3. Do you agree with the proposed changes to the section 'The right to be fully informed' as outlined above and set out in the draft?

The RACP agrees with the proposed changes.

4. What other changes, if any, should Council include in the section 'The right to be fully informed'?

This section is titled "the right to be fully informed". The RACP regards the use of the word "fully" to describe the degree to which the patient is informed as a superlative which cannot describe the reality. "Fully informed" is a fallacy in the context of information and informed consent – it is impossible for the patient and their whānau to be provided all known information about a procedure, treatment or management of a medical condition. As medical practitioners, the best that we can do is provide some information; we note that the reality will be that medical practitioners are necessarily selective with regards to the information that is provided.

The RACP recommends an additional paragraph is inserted following paragraph 7, which details Right 6 of the Code. The inserted text would read as:

> "*It is not sufficient to disclose only your recommended option. See HDC Opinion 02HDC18414, where the Commissioner noted, "Surgeons have a responsibility to locate their own opinions within the spectrum of professional views about possible procedures and to contextualise their recommendations, rather than simply 'announce' their stance*"[1].

We recommend Council make some amendments to paragraph 13 to clarify and clearly articulate the circumstances where a patient's right to be fully informed could be waived:

(a) *In exceptional* circumstances you *may* decide, in the absence of a refusal by the patient, to delay the provision of information because you believe that providing it at that time may result in harm to the patient

Regarding the Health Practitioners Disciplinary Tribunal case involving Dr John Harman, which is cited in this section, it is adequate to refer to this case as Re Harman (55/Med06/37D), rather than singling out Dr John Harman.

---

[1] Health and Disability Commissioner. Decision 02HDC18414: Failure to discuss option of radical surgery for brain tumour. [Internet]. Auckland: Health and Disability Commissioner; 2004. Available from https://www.hdc.org.nz/decisions/search-decisions/2004/02hdc18414/. Accessed 5 June 2019.

5. Do you agree with the proposed changes to the section on ‘Informed choice and consent’ as outlined above and set out in the draft?

The RACP is supportive of the additions to the Statement covering telehealth, statements specifying that doctors should only manage aspects of the informed consent process for which they are competent (with reference to Council’s resource on ‘Prevocational training’), and encouraging doctors to involve whānau and caregivers, which may improve culturally safe practices.

6. What other changes, if any, should Council include in the section on ‘Informed choice and consent’?

In the new paragraphs on delegation, we question whether the Statement should footnote that the responsible supervisor/consultant may still be held responsible for any failure by the delegated doctor to give sufficient information and obtain fully informed consent, at least where it was not reasonable to delegate the task to the particular junior doctor: See *McKenzie v Medical Practitioners Disciplinary Tribunal* [2004] NZAR 47 (HC).

We suggest Council removes the word “innovative” in paragraph 20, as it has positive connotations which may be interpreted by medical practitioners and members of the public in a manner unintended by Council. We do not recommend “innovative” is replaced with another word.

7. Do you agree with including a section about time and resource constraints, and how that impacts on doctors when communicating with patients about their care and treatment?

The RACP is supportive of the new section on ‘time and resource constraints’, as it acknowledges the reality that external pressures and competing demands may result in doctors spending less time with patients, their caregivers and whānau. The recommendation to utilise the knowledge, skills and expertise of the multidisciplinary team to support information transmission is supported.

However, it is important to note that some patients may experience racism, marginalisation and disenfranchisement as a result of health care interactions. These experiences can contribute to patients receiving a lower quality and standard of care, which in turn contributes to inequities and poor health outcomes[2]. Although time is often pressured, it is important for doctors to ensure their practice is culturally competent, and patients, caregivers and whānau are not subject to individual or institutional bias.

8. What other changes, if any, should Council include in the section on ‘Time and resource constraints’?

In paragraph 23, the wording “and any reasonable adjustments” could be deleted as it is overly vague. We see the remaining wording “… have the time *and* support they need …” as adequately covering the intent of the removed text.

---

[2] Jansen P, Bacal K, Buetow S. A comparison of Māori and non-Māori experiences of general practice. [Internet] N Z Med J 2011; 124(1329): 24-9. Available from http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2011/vol-124-no-1330/article-jansen. Accessed 7 June 2019.

9. Please provide any feedback you would like us to consider in relation to the proposed section ‘When a patient is anaesthetised’

We suggest some additions to paragraph 30 “When a patient is anaesthetised” to define the role of the medical practitioner and for clarity, as italicised below:

> “There may be occasions where the clinical presentation of an anaesthetised patient warrants further investigation or intervention, where the patient has not *given or refused consent for the further investigation or intervention*. Good clinical judgement is needed as to whether to proceed, or to defer that additional investigation/intervention until you have discussed it with the patient and obtained the patient’s consent. *The urgency of following up the unexpected immediately, rather than waiting to seek the patient’s consent, is a key consideration*. You should discuss any unexpected intraoperative findings with a peer, a clinical head or your Chief Medical Officer, and must document your discussion(s) with the patient including any decisions that are made about proceedings with or deferring the additional investigation or intervention”.

10. Please provide any feedback you would like us to consider about obtaining the patient’s consent if an observer attends the consultation

The RACP recommends some additional wording is included in this section to clarify Council’s intention. For paragraph 37 and 38, our suggestions are italicised below:

> Obtain consent before involving medical students in the care of patients. *Fully* inform the patient about the extent of the *proposed* involvement of the student, and the student’s experience[3].
>
> You must also obtain the patient’s consent *if it is proposed that* an observer attend the consultation, *before the observer joins the consultation*. This is especially important if sensitive issues are *to be* discussed and/or intimate examinations conducted. *Fully inform* the patient about the *proposed* role *for the observer* and what is expected of the observer.

11. Please provide any feedback you would like us to consider in relation to the section on ‘Advance directives’

The new section on advance directives is welcomed by the RACP. We have some suggested amendments to paragraph 39 below (in italics) to add clarity to the statements.

> “An advance directive is an oral or written instruction that outlines or describes the patient’s wishes in a specific situation. Under Right 7(5) of the Code ‘Every consumer may use an advance directive in accordance with the common law’. *An advance directive is defined in clause 4 of the Code to mean ‘a written or oral directive (a) by which a [patient] makes a choice about a possible future health care procedure; and (b) that is intended to be effective only when he or she is not competent.* If a patient has an advance directive, you are obliged to follow it unless there is *good* reason to question its validity or *applicability* to the situation.”

---

[3] The RACP regards the use of the adjective “fully” in the context of informing a patient as to the proposed involvement of a student to be appropriate.

Other comments on the Statement

In the section "Where a patient is not competent to give informed consent", the RACP recommends Council consider inserting additional text as examples where the competence of the patient may affect their ability to give consent. These are detailed in italics below:

> "In some circumstances it may not be possible to obtain the patient's informed consent. For example, *a young child or unconscious patient*, *or a patient with significant* dementia or *major* intellectual disability. In such cases, you should try to contact a legal guardian or *holder of an enduring power of attorney*. The only individuals who are entitled to grant consent on behalf of a patient are legal guardians (welfare guardians under the Protection of Personal Property Rights Act, or parents/guardians under the Guardianship Act), or someone with enduring powers of attorney. In certain circumstances you may provide a service in the best interests of a patient without receiving consent (refer to paragraphs 26-27)."

The RACP finds the section "Informed choice and consent that is part of research" could be augmented by additional references to the Code. We have included our recommended amendments to paragraphs 35 and 36 below in italics:

> All research must be approved by an accredited ethics committee before patients are invited to participate and give consent to involvement in the study. There is special responsibility when a proposal includes investigative research or a trial of treatment. Under Rights 9 *and 6(1)(d)* of the Code, informed consent is necessary whenever a patient participates in research. If any form of the research is changed or amended once informed consent has been obtained, you must *disclose the relevant information to the patient and seek their fresh* informed consent."
>
> "If the treatment is part of research, it is the responsibility of the investigating doctor to take all reasonable steps to enable the patient to understand the full implications of the treatment, especially the uncertainties. Written consent from a patient is required for research, *under Right 7(6)(a) of the Code*."

Comments on the Appendix

The Appendix to the Statement covers specific statutory references in current legislation. The RACP recommends some additions are made for clarity in relation to some of the Acts cited. Suggestions are included in italics:

> ***New Zealand* Bill of Rights Act 1990**
> "The *New Zealand* Bill of Rights Act *1990 sets out* a number of fundamental rights and freedoms *(including the rights noted in paragraphs 46-48 below), which may be relevant to proposed medical treatment.* Where specific legislation, such as the Code of Rights, *appears to be in conflict with the Bill of Rights, courts will closely scrutinise whether it is necessary (as a matter of statutory interpretation) and reasonably justifiable not to uphold the right affirmed in the Bill of Rights.*"

We note that the Appendix does not currently include a reference to relevant sections under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. This would include references to sections 52 (2) and 62 clauses (1) – (3).

Conclusion

The RACP thanks Council for the opportunity to provide feedback on this consultation. To discuss this submission further, please contact the NZ Policy and Advocacy Unit at policy@racp.org.nz.

Naku noa, na

Dr Jeff Brown
New Zealand President
The Royal Australasian College of Physicians