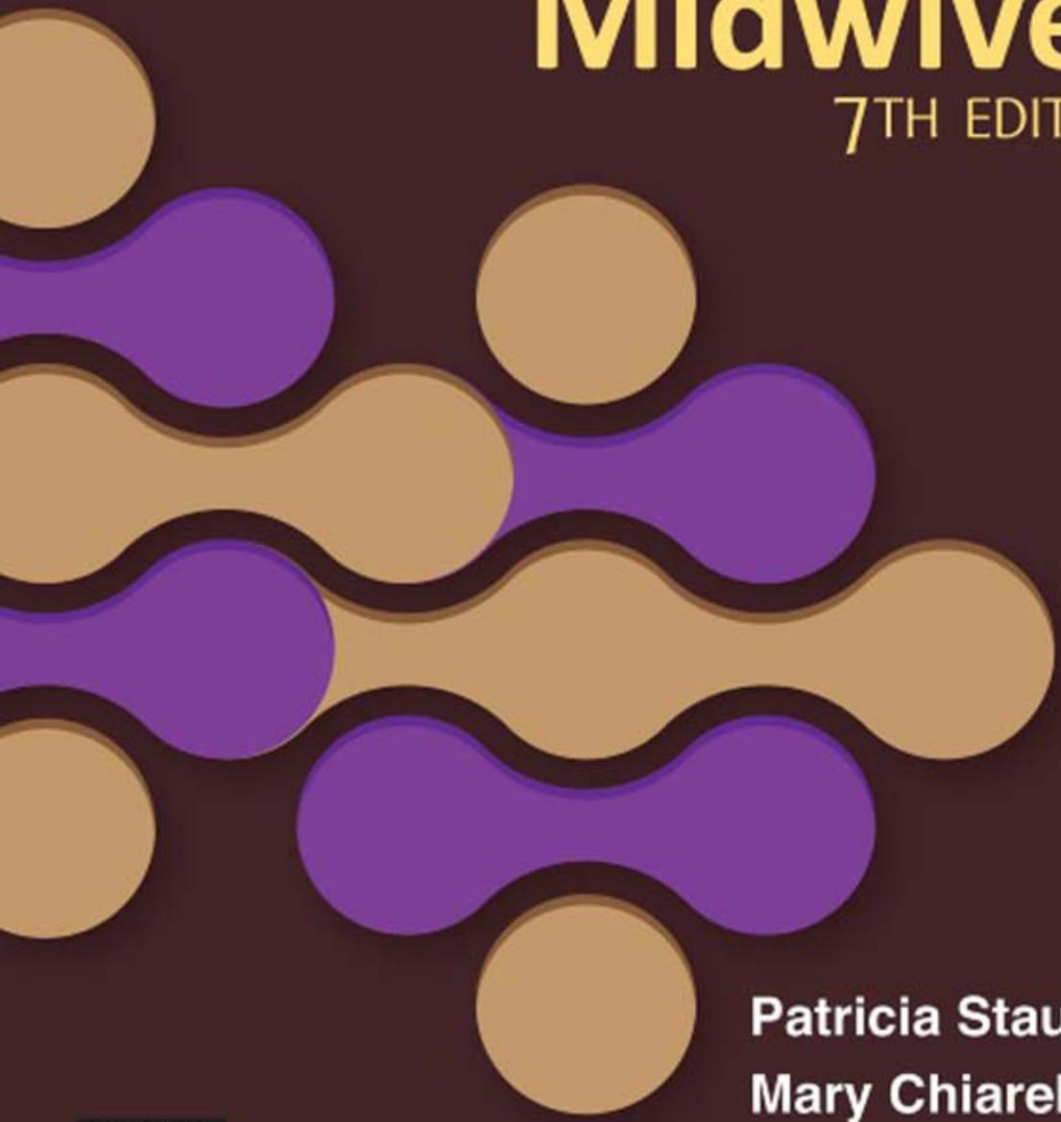
LAW FOR Nurses AND Midwives

7TH EDITION



Patricia Staunton
Mary Chiarella

CHURCHILL LIVINGSTONE
ELSEVIER

This page intentionally left blank

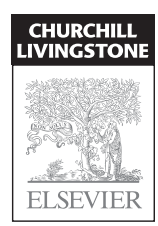
LAW FOR Nurses AND Midwives 7e

This page intentionally left blank

LAW FOR Nurses AND Midwives 7e

Hon Justice Patricia J Staunton AM RN, CM, LLB, MCrim; Barrister-at-Law of the Inner Temple, London

Professor Mary Chiarella RN, RM, LLB (Hons), PhD (UNSW)



Sydney Edinburgh London New York Philadelphia St Louis Toronto

Churchill Livingstone
is an imprint of Elsevier

Elsevier Australia. ACN 001 002 357
(a division of Reed International Books Australia Pty Ltd)
Tower 1, 475 Victoria Avenue, Chatswood, NSW 2067

eISBN: 9780729581028

National Library of Australia Cataloguing-in-Publication Data

---

Author: Staunton, Patricia J.
Title: Law for nurses and midwives / Patricia J Staunton and Mary Chiarella.
Edition: 7th ed
ISBN: 9780729541022 (pbk.)
Subjects: Nursing–Law and legislation–Australia. Midwives–Legal status, laws, etc–Australia.
Other Authors/Contributors: Chiarella, Mary.
Dewey Number: 344.940414

Publisher: Libby Houston
Developmental Editor: Elizabeth Coady
Project Coordinators: Geraldine Minto & Karthikeyan Murthy
Edited by Desanka Vukelich
Proofread by Jon Forsyth
Cover and internal design by Lisa Petroff
Index by Robert Swanson
Typeset by Toppan Best-set Premedia Limited
Printed in China by 1010 Printing Int'l Ltd.

Contents

Dedication

To my parents with love and affection. Patricia Staunton

For Laurie. Mary Chiarella

Preface

It has always been our goal to provide nursing students and practising nurses with an introduction to the legal issues relevant to the provision of health care in Australia, and do so in a practical and readily understandable text with a clear, concise and readable exposition of the law.

With the recent changes to regulations for nurses and midwives under National Registration, we have updated the seventh edition of *Law for Nurses and Midwives* with the aim of reflecting these standards, and as the new title indicates, incorporated legislation relevant to midwifery practice.

All chapters have been revised and updated to reflect recent changes in legislation and regulations relating to nursing and midwifery practice, as have references to relevant court decisions. Special attention has been given to areas where legislative provisions apply, such as professional standard of care, occupational health and safety, coroners' jurisdiction and mental health, to ensure that a nationwide perspective is provided.

Chapter 8 *Professional regulation of nurses and midwives* has undergone a complete rewrite to incorporate the new standards and regulations established by the Nursing and Midwifery Board of Australia (NMBA) for National Registration, and includes a specific section on maternity services law to address the new standards and guidelines for eligible midwives.

As always, we are extremely grateful for the comments and feedback we have received from readers and professional critics of our text to ensure it remains relevant to those who use it.

Again, we thank our own staff who have provided us with assistance in undertaking our task as well as our publishers for their support and patience during the writing of the seventh edition.

We trust this most recent edition of our text continues to provide assistance to all who use it and we thank them for their encouragement and interest in the ongoing editions of this text.

Reviewers

Lyn Francis BN, MHM, LLB, LLM, G.Cert PTT
Lecturer, School of Nursing and Midwifery, Faculty of Health, University of Newcastle, NSW Australia

Amanda Stott, RN, BSocSc (Psych), MEd
Lecturer in Nursing, Academic Advisor, Charles Sturt University, Bathurst, NSW Australia

Table of abbreviations

A

AIMS	Advanced Incident Management System
AC	Appeal Cases
ACORN	Australian Council of Operating Room Nurses (now the Australian College of Operating Room Nurses)
AHEC	Australian Health Ethics Committee
AHWAC	Australian Health Workforce Advisory Committee
AIRC	Australian Industrial Relations Commission
ALJ	Australian Law Journal
All ER	All England Reports
ALR	Australian Law Reports
ANMC	Australian Nursing and Midwifery Council
APAC	Australian Pharmaceutical Advisory Council
ART	assisted reproductive technology

C

CCO	continuing care order
CHF	Consumer Health Forum
CLR	Commonwealth Law Reports
COAG	Council of Australian Governments
CTO	community treatment order

D

DEST	Department of Education, Science and Training

E

ECT	electroconvulsive therapy
EHR	electronic health record

I

IIMS	Incident Information Management System
IIS	Incident Information System

J

J	Judge

L

LQR	Law Quarterly Review
LRC	Law Reform Commission

N

NEHTA	National e-Health Transition Authority
NHMRC	National Health and Medical Research Council
NMBA	Nursing and Midwifery Board of Australia
NSWLRC	NSW Law Reform Commission
NSWR	New South Wales Reports

P

P	President

Q

QB	Queens Bench
QC	Queens Counsel
QPD	Queensland Parliamentary Debates

R

RCA	root cause analysis

S

SAC	Severity Assessment Code
SASR	South Australian State Reports

W

WLR	Weekly Law Reports

Chapter 1

Introduction to the law

A knowledge of the law as an adjunct to a primary area of activity such as nursing and midwifery requires that, in the first instance, the nurse or midwife has a rudimentary understanding of what the law is, where it comes from and how it operates. Such an understanding is essential to enable them to extract from a seemingly complex system sufficient practical information to be of benefit to them in their professional activities.

Understanding what the law is

It is not desirable or necessary, in our view, to seek to precisely define what the law is. What is more important is to understand the rationale behind the development of the law and its role in society.

The sophisticated and complex legal system that exists in Australia today represents the development of many centuries of Western civilisation. The discovery and colonisation of Australia by England over 200 years ago saw the adoption in this country of the legal system and principles that existed in England at that time. The English legal system, as it then was, originated in primitive community or village systems and its historical development can be traced back over centuries of invasions. These primitive communities recognised even then the need for rules of behaviour which encompassed respect for each other and each other's property to ensure a degree of order in the community.

Hand in hand with such recognition was the inevitable desire for dominance and power of man over man, which has played such a major role in the development and subsequent decline of civilisations over the centuries.

Inevitably what started as a primitive and crude system for rules of behaviour, operating on an individual community or village basis, was forced to develop and change over the centuries. This development and change was brought about by population growth, the diversity and sophistication of community systems, and rapid industrial and technological growth.

The law essentially comprises rules of behaviour to do with the recognition of personal and property rights. Within that process certain philosophies have clearly

influenced, and continue to influence, the development of such rules. Primarily these are referred to as natural law and positive law philosophies.

Natural law philosophies, as a general rule, saw the origins of law arising from a higher or divine being which encompassed the notion of divine retribution operating in human affairs. Such a philosophy embraced the concept of sin as a transgression against the divine will, or contrary to certain principles of morality.

The development of the Greek civilisation, and to a lesser extent the Roman civilisation, was influenced by such natural law philosophies (in the shape of their gods), which stressed individual worth, moral duty and universal brotherhood. Such philosophies were developed further during the medieval period in Europe by the increasing influence of the Catholic Church, which set the tone and pattern of all speculative thought. The Catholic Church pursued this natural law view as law derived from God with one faith, one church, one empire — not man-made but conceived as part of the universe.

In summary, natural law philosophies look upon situations as they might or ought to be, as opposed to how they are. It is essentially an idealist notion with strong moral overtones. As an example, the United Nations Declaration of Human Rights is essentially a natural law document.

Positive law philosophies view law in a totally secular cast without regard for divine prescriptions or intervention. Such views emerged during the renaissance period of European history (fourteenth to sixteenth centuries), which saw the rise of independent national states and churches, and emphasis on the individual. Further development occurred during the nineteenth century when states were established with absolute sovereignty not subject to an external natural law. The industrial revolution and the development of science supported this imperative theory of law, which saw the key concepts of law as being:

a) the command;
b) of a sovereign (used in this context sovereign means the person or party in power);
c) backed by a sanction (that is, the penalty imposed for non-compliance with the command of the sovereign).

Such a view of the law takes no account of morality and indeed positive law is most evidenced in the rigid separation of law and morals.

Influence of the different philosophies on the development of our laws

Natural law philosophies have had their greatest impact on the development of the legal systems of Western civilisation in shaping statements of ideal intent. As an example, the United States Constitution states that the individual has the right to certain fundamental freedoms — two of which are the freedom of speech and freedom of the press. Although such rights are guaranteed in the Constitution, such rights are not absolute in practice, as they are subject to constraints that prohibit that freedom in certain circumstances. As an example, the freedom of the press is subject to the laws of defamation, which will prevent the publication of material in particular circumstances. Nevertheless, it is the *intent* of the United States Constitution to guarantee absolute freedom of speech and of the press, so that every citizen

and the press should be able to speak their mind and state their views freely, without fear of reprisal.

Natural law philosophies have also been responsible for the continuing influence of morality in shaping some of our present laws, much to the disapproval of positivist lawyers who believe morality should play no part in such an activity. As an example, two areas of law-making where morality and religious influences have played a significant role in shaping the present law have been the contentious areas of abortion and homosexuality.

The positive law view that law is a command of a sovereign backed by a sanction means that no regard should be paid as to whether or not the command of the sovereign may be immoral by community standards. The mere fact that the sovereign has the power to command and impose a sanction for non-compliance legitimises such a command. An example of such a situation is the international legal recognition that is given to governments of various countries whose government regimes would be considered by any moral standards to be odious and repressive. Both philosophies have had an impact on the laws that we have today and will have in the future.

Where does our law come from?

As a legacy of our colonisation by England, Australia as a nation inherited many of England's laws — certainly its legal principles — and in doing so the historical development of its legal system. Therefore, it is necessary to examine briefly the history of the English legal system in order to understand ours.

The historical development of the English legal system saw the emergence of two major sources of law:

1) common law;

2) parliamentary or statute law.

Development of the common law

To understand how the common-law principles developed it is necessary to appreciate that the land mass known to us as England and Wales was not always the densely populated modern community that it now is. The initial development of English common-law principles to be established on a central unified basis goes back to the time of Henry II, who ruled England from 1154 to 1189. At that time Henry's kingdom consisted of a large number of feudal villages, each presided over by the feudal lord or chief of the village. Communication as we know it did not exist, battles between warring factions were not uncommon and Henry was having the usual problem of maintaining power and control over his kingdom that English monarchs were wont to have in those times. The law, as then understood and applied, consisted of the rules of the individual villages, generally based on custom, which were administered and interpreted by the feudal lord of the village. Such rules were generally arbitrary and subjective, were changed frequently and varied from village to village. In an attempt to unify his kingdom and as an alternative to the capricious and variable nature of the individual village laws, Henry offered his subjects access to his law, known as the King's law. This law was also based on

custom but had the great advantage of universal application. Henry arranged for his knights to visit each village in his kingdom on a regular basis to deal with disputes that had arisen. The villagers had the choice of being dealt with by the feudal lord according to the laws of the village, or they could wait and be dealt with by the King's knight according to the King's law. The King's emissary was usually fairer, as he was able to be more objective and his decisions were more certain and predictable. In due course more and more people chose to have disputes dealt with in this way and gradually the King's law supplanted the village law system completely.

In offering an alternative system of development and administration of law to his subjects, Henry II was also responsible for commencing the first central unified system of law reporting. In travelling from village to village, not only did his knights attempt to administer the law fairly and objectively but, having applied certain principles to a particular set of facts in one village, they would do so in all future situations where the same facts arose. In order to be able to do that, they kept notes of the cases they had dealt with and referred to them as required. The recording of previous decisions and the facts upon which they were based saw the emergence of certain principles concerning personal and property rights, which became established and were known as *common-law principles*. As communities developed and society became more complex and sophisticated, those well-established principles were expanded and developed by the courts and judges who had long replaced Henry's knights of old.

The common-law principles that were established as part of the King's law gradually became rigid and inflexible — often with unfair results. To overcome the rigidity of the King's law, the *law of equity* was developed. This consisted of the application of equitable principles, which attempted to soften the often harsh consequences of the common law. An example of a well-established equitable principle is the recognition given to a wife's interest in the matrimonial home. A wife may not have made a direct financial contribution to the matrimonial home and her name may not be registered on the certificate of title as a joint owner of the property; however, the courts will recognise that her contribution towards the maintenance and upkeep of the home and family entitles her to have an equitable interest in the property, which can then be financially apportioned. Over the centuries those equitable principles recognised by the courts have also become fixed and rigid in their application. Nevertheless, that body of law known as equity and the principles developed by it are as well established and applicable today as the common-law principles.

It is interesting to speculate that the present-day District or County and Supreme Courts, which travel to cities and towns in each state and territory for one or two weeks at a time to administer the law, owe their origins to the primitive system of the King's knights travelling on horseback from village to village administering the King's law.

Clearly, the 850 or so years that have passed since Henry II's time have seen the continued development by the courts of the common-law legal principles. Such principles are well enunciated and recorded in the present sophisticated system of law reporting, which represents the history of such development through decisions of the courts. The principles enunciated in the recording of cases in the law reports

are the authorities relied upon by lawyers to support a legal argument based on common-law principles. This is sometimes referred to as *case law*.

As the court system developed, applied the common-law principles and recorded them, certain power struggles were developing, centred on the perceived divine right of the monarchy and the right of the people to have a say in the affairs of government. This struggle culminated in the establishment of the second major source of our law — parliament.

Parliamentary or statute law

The institution of parliament as we know it today, with the power to make and unmake laws, was the result of many years of turmoil and struggle in English history. The long-established divine right of the monarchy, with the power to make and unmake laws and to tax the people at will without accountability, was gradually eroded by increasing demands for representation and participation in government. Out of the demands for representation and participation came the early beginnings of a parliament representative of the people. One of the powers which the early parliaments soon took upon themselves and away from the monarchy was the power to make laws. Although parliaments have also changed in complexity and sophistication, their fundamental right to make laws has remained unchallenged. In the last century particularly, parliaments have increased their law-making role significantly, in order to keep pace with social, industrial and technological changes in the community. In addition, many of the well-established common-law principles have been extended or replaced by statutory laws to take account of such changes.

Laws created by a parliament are embodied in documents known as *Acts* of that parliament and commonly referred to as *legislation*. When a document concerning a particular matter is placed before a parliament with the intention of creating legislation it is known as a *Bill*. Once it has been passed by both houses of parliament (with the exception of Queensland, which has only a lower house) and subject to any amendments on the way, it then receives the Royal Assent from the Queen's representative and is formally proclaimed an Act of parliament. The provisions of an Act are known as *statutory law* (or statutory authority). Acts of parliament often have a separate document known as *Regulations*, which accompany the Act and should be read in conjunction with it. The Regulations generally give precise directions which must be followed in order to comply with the intent of the Act; for example, the Regulations relating to the New South Wales *Poisons and Therapeutic Goods Act 1966*.

Apart from their role in expounding and applying the common-law principles, the courts are now increasingly occupied in interpreting the statutory law passed by the relevant parliaments.

The application of English legal principles to Australia

The inheritance of the principles and sources of law arising from our colonisation by England laid the groundwork for the development of our legal system.

The English common-law principles have been universally adopted throughout the states and territories of the Commonwealth as the basis for future development

of the law. There were also English statutes which provided constitutions for each of the Australian states and territories. For example, the English Act referred to as *4 George 4* (1823) established the New South Wales Legislative Council, with the power to make laws for the peace and good government of New South Wales. This power was clarified by another English Act known as the *Australian Courts Act* (1828) which stated that English law was to be applied 'so far as it can be applied'; that is, the state was given its own parliament with the power to make laws for New South Wales. The same approach was followed as the other states of Australia were settled and developed. The end result was that, prior to Federation, the land mass known as Australia consisted of a number of self-governing and independent colonies of the United Kingdom. However, the creation of the Federation in 1901, with concurrent parliamentary systems in each state, and their inherent law-making powers, posed significant problems.

The creation of the Federation pursuant to the *Commonwealth of Australia Constitution Act 1901* (Cth), which was passed by the United Kingdom Parliament, established a Commonwealth Parliament, and the former colonies became states of the Commonwealth of Australia. In the same Act, exclusive powers to make laws in relation to certain areas were given to the Commonwealth Parliament. Those areas are set out in section 51 of the Act, and include such common policy matters as customs, currency, overseas trade, defence, and divorce and matrimonial causes. At the same time the same section provided for the sharing of certain powers between the Commonwealth and the states and territories. Such powers are known as *concurrent powers*. By implication, matters not mentioned in section 51 or elsewhere in the Constitution comprise the powers that can be exercised exclusively by the state or territory parliaments.

The outcome of such a sharing of powers with the right to make laws in relation to them means that all Australian citizens are subject to the laws of two parliaments — the Commonwealth Parliament and the parliament of the state or territory in which they reside. Understandably it can sometimes be confusing.

As far as the power to make laws in relation to health is concerned, it is a concurrent power shared between the Commonwealth and the states and territories. For example, the Commonwealth has responsibility for the legislation underpinning the funding of Medicare and general health insurance. Consequently, the Commonwealth has control over the level and extent of financial rebate that is paid by Medicare for general practice fees and medical specialist consultation fees. It also controls the level of fees able to be charged by health insurance companies and administers and subsidises the Pharmaceutical Benefits Scheme available to all Australians in relation to the cost of approved and prescribed medications. However, it is state and territory governments that have control of and responsibility for the delivery of hospital and public health services as well as a broad range of community-based public healthcare services. In 2012, the Commonwealth has introduced a number of sweeping changes to the funding arrangements for the public hospital system in Australia that will see the Commonwealth have a much more direct say in the delivery of public hospital services throughout Australia.

A significant change to the registration of health professionals has occurred since 1 July 2010. Prior to that date, each state or territory was responsible for registering

the diverse range of health professionals who wished to practise in a particular state or territory and a nurse or widwife had to be registered in each state or territory where she or he wished to practise.

As of 1 July 2010, a National Registration scheme for health professionals, including nurses and midwives, has been implemented throughout Australia. The new system is known as the National Registration and Accreditation Scheme (NRAS) for health professionals. This significant legislative change titled the *Health Practitioner Regulation (Consequential Amendments) Act 2010* (Cth) now means that nurses and midwives only need to hold one licence to practise in order to work as a nurse or midwife in any state or territory.

There is now a National Nursing and Midwifery Board of Australia to oversee the changes. Full details of the changes made and the implications for nurses and midwives in relation to their practice responsibilities are found in Chapter 8.

It is nevertheless important to remember that although the common-law principles do not vary from state to state or territory, and apart from the national approach introduced in relation to the regulation and registration of health professionals, there are still specific provisions of individual state or territory legislation in relation to the delivery of health services that can, and do, vary between each state and territory. For example, each state and territory has its own *Mental Health Act* that, while generally consistent in their respective approaches, do vary. The same applies to the legislation relating to the control and supply of poisons and prohibited substances which governs the administration of dangerous drugs and drugs of addiction in each state and territory.

Nurses and midwives quite often move freely between the states and territories seeking employment. Accordingly, when such a shift is made it is important that differences in legislative provisions which are relevant to a nurse's or midwife's employment are known and emphasised.

When a situation exists where two parliaments have power to make laws in relation to a particular area, it is not surprising that conflict may arise, as it has in the past. When this occurs, section 109 of the Constitution provides that, to the extent of the conflict, the Commonwealth law shall prevail. An example of where such an argument was successfully raised is the conflict that arose between the Tasmanian and Commonwealth governments in the controversial *Tasmanian dams case* (1983)[1] when the Commonwealth prevailed and blocked the intention of the Tasmanian Government to dam the Franklin River as part of its hydroelectric scheme for the state. In that case, the High Court ruled the Commonwealth could prevent a state authority from damaging the environment, even though the Commonwealth had no express power in the Constitution to legislate on environmental protection. The High Court decision was based predominantly on the Commonwealth's ability to give effect to international treaties.

A more recent example of conflict of powers between the Commonwealth and the states was the High Court decision in the *WorkChoices amendments case*, handed down on 14 November 2006.[2]

In that case, the states had challenged the Federal Government's move to amend the Commonwealth *Workplace Relations Act 1996* by inserting what is widely referred to as the *WorkChoices amendments*. The challenge was unsuccessful and the

WorkChoices amendments were affirmed by the High Court as constitutionally valid.

The purpose and intent of the WorkChoices amendments was to give to the Commonwealth the power to regulate the employment conditions of nearly 80 percent of the country's workforce. In asserting such a power, the Commonwealth relied on the corporations power as expressed in section 51(xx) of the *Commonwealth of Australia Constitution Act*. That power allows the Commonwealth to make laws relating to 'foreign corporations, and trading or financial corporations formed within the limits of the Commonwealth'. Such corporations are generally referred to as 'constitutional corporations'.

Further reference to the impact of the WorkChoices amendments on the industrial regulation affecting the employment of health personnel, including nurses and midwives, is to be found in Chapter 5.

It is always possible for a state to voluntarily hand over or refer one of its constitutional powers to the Commonwealth — with or without conditions. For example, early in 2007 the Commonwealth was pressing the states of New South Wales, Queensland, South Australia and Victoria to refer to it the power to take control of water management, particularly of the Murray–Darling Basin. If that was to occur, it would undoubtedly be subject to the Commonwealth's meeting certain conditions and making significant payment to the states concerned.

How the law operates

Before turning to a consideration of how the law functions administratively, it is necessary to divide the law into two distinct areas:

1) criminal law;
2) civil law.

It is essential that such a distinction is grasped from the very beginning, as otherwise it makes it difficult to understand and follow the legal process. The question that often arises is 'What is the difference between civil and criminal law?'.

Criminal law

The best way to think of the criminal law is that it is essentially rules of behaviour, backed by the sanction of punishment, which govern our conduct in the community, having regard to other people and their property. Most of us are aware of the more common rules of behaviour; for example, not taking another person's property, not assaulting another person, or not exceeding the speed limit. The power which resides in the parliament enables it to determine the rules in conjunction with acknowledged community views as to what constitutes accepted rules of behaviour in the community. The parliament or, more correctly, the government in power, then seeks to control our behaviour in the community by ensuring that we obey the rules or face the sanction of punishment. This process is done by way of delegated authority to a government body. In criminal law, the power to ensure that we obey the rules of behaviour rests with the police force. Their task, in the first instance, is to adopt a preventive role and, in the second instance, to 'catch' us when

we do break the rules. Having done that, the police must, via the relevant prosecuting authority, then charge the person (the accused) with a breach of the rules (an offence) and then the prosecution must prove that the accused committed the offence as charged. The task of having to prove the offence as charged is known as having the *burden of proof* or *onus of proof*. In satisfying the burden of proof, the prosecution must prove the offence according to the criminal law *standard of proof* — that is, beyond reasonable doubt. The task of proving an offence in accordance with the standard of proof is done by producing evidence from a number of different sources, for example:

- evidence of identification and relevant events from the victim (if possible);
- direct evidence of eyewitnesses who saw the offence being committed;
- medical or scientific evidence by experts;
- written or verbal admissions made by the accused.

The elements that must be established to prove that a person has committed a criminal offence as charged are dealt with further on in this chapter.

A criminal charge will be dealt with in court, generally before a judge and jury or before a magistrate sitting alone. More serious matters are dealt with by a judge and jury, with the jury having the task of deciding the guilt or innocence of the accused based on the evidence presented. The role of the judge in such trials is to determine points of law and ultimately sentence the accused if he or she is found guilty. In less serious criminal matters a magistrate will hear and determine the matter without a jury and sentence the accused. The degree of the punishment will depend on the nature and seriousness of the offence and can range from fines, bonds, community service orders, periodic detention and home detention, to imprisonment.

In addition to the normal type of criminal offences that most people think of when they think of the criminal law — that is, assault, robbery, theft, fraud and so on — there are other categories of criminal offences that individuals or companies can commit. For example, companies and/or individuals can be prosecuted for environmental, occupational health and safety, or corporate law offences.

Unless the accused is acquitted of the offence, the outcome of the criminal law process is punishment. How does the above process differ from the civil law?

Civil law

The first thing to remember about the civil law is that, generally speaking, it has nothing whatsoever to do with the police force and punishment. The best way to think of the civil law is that it exists to enable us, individually and collectively, to resolve the disputes and differences of a personal and property nature that arise between us as members of the community and which we are unable or unwilling to resolve ourselves. As a general rule in resolving such disputes, monetary compensation (damages) will be sought by the person or party alleging personal and/or property loss and damage. There are many divisions of the civil law; for example, family, industrial, land and environment, and workers compensation, to name just a few. There is also what is known in civil law as a common-law division

and into that division are allocated those matters whose origins are the well-established common-law principles, such as contract law, negligence, defamation or nuisance.

The person or party who initiates an action in the civil law is known as the *plaintiff* and the person against whom the action is taken is known as the *defendant*. There are exceptions to this; for example, in family law the person seeking a divorce is the *applicant* and the spouse from whom the divorce is sought is the *respondent*.

Similar to the requirement in criminal law, the person who brings an action in one of the areas of the civil law (the plaintiff) bears the burden of proving the matter in dispute. The significant difference here is that, although the plaintiff has that onus, the standard of proof in civil matters is not the same as in criminal matters. In a civil action the plaintiff has to prove his or her case only on the balance of probabilities. What this means is that the evidence would disclose that, on balance, the allegation made by the plaintiff, when considered with the evidence produced, and in light of the law as currently applying, is the most probable cause of the matter in dispute. Such a standard is clearly a much lower standard of proof than that required in the criminal law.

When the plaintiff succeeds in proving the matter in dispute, the final and most important issue to be determined by the court will be the amount of monetary compensation (damages) to be awarded to the plaintiff. In most circumstances, the outcome of the civil law process is compensation. There are some exceptions to this and the civil law does provide for other remedies which may compensate the plaintiff. For example, the court could order that the defendant do a certain thing (specific performance) or that the defendant refrain from doing a certain thing (an injunction). However, as a general rule, the awarding of a sum of money to the plaintiff is seen as the most appropriate way of resolving the dispute between the parties.

What is important to remember in the awarding of monetary compensation by a court is that the court itself does not actually give the money awarded to the plaintiff. The court hands down a judgment identifying the amount of compensation it determines the plaintiff is entitled to. The plaintiff must then recover that money from the defendant. In most civil litigation that means recovering the money from the defendant's insurance company. However, if there is no relevant insurance company standing behind the defendant and the defendant is impecunious then the plaintiff may well be left without compensation. It is a salutary reminder of one of the pitfalls of civil litigation.

Civil and criminal consequences from one action

Having taken pains to distinguish between the civil and criminal law processes, it is now necessary to muddy the waters somewhat and point out that one incident can give rise to both civil and criminal law proceedings. For example, while driving your motor vehicle one day you wrongfully fail to give way to traffic on your right at an intersection and, as a result, an accident occurs and a number of people in the other vehicle are badly injured. The police will be called and you, as the driver of the vehicle that caused the accident, will be charged with a number

of offences such as negligent driving and failing to give way. Your action and the charge that follows is deemed to be a criminal act pursuant to the legislation covering motor traffic offences in your state or territory, and in due course you will be dealt with before the appropriate court. Assuming your guilt, you will then be punished — you will probably be fined, your licence may be taken away or an even more severe penalty may be imposed, depending on the culpability of your action.

However, the persons that you have left badly damaged at the scene of the accident may not be so concerned (although they might well be) with whatever punishment the court may wish to mete out to you as a result of your criminal act. They could be more concerned with seeking some money from you in order to compensate them for the pain, injury, loss and suffering that you have caused them as a result of your negligent act — that is, your *civil wrong*. Those persons will commence an action against you and they will allege that, on the basis of certain facts, you drove your car negligently, as a result of which they suffered certain damage. They will have to prove, on the balance of probabilities, the facts and damage they are alleging. Assuming they are successful, they will be awarded a monetary amount (damages) as compensation for their injuries and the subsequent losses that flow from those injuries.

It will be seen from the above example that the major distinction to be drawn between the civil and criminal act *resides not in the nature of the wrongful act but in the legal consequences that may follow it*. If the wrongful act is capable of being followed by what are called *criminal proceedings*, that means that it is regarded as a *crime* (otherwise called an offence). If it is capable of being followed by *civil proceedings*, that means that it is regarded as a *civil wrong*. If it is capable of being followed by both, it is both a crime and a civil wrong. Civil and criminal proceedings are (usually) easily distinguishable; the procedure is different, the outcome is different and the terminology is different.[3]

Administrative machinery of the law

In its day-to-day operation the administration of the law is also divided along criminal and civil lines. In addition, there is a hierarchical structure which determines:

- what matters can be dealt with by particular courts;
- the powers that are vested in the different courts to deal with matters that come before them;
- if a right of appeal exists from a particular court, how and in what circumstances it is to operate.

All the states and territories have a similar basic hierarchical structure of the administration of the law. The titles of the courts may vary from state to state or territory, but not to any significant degree. The following summary of the roles of the various courts should be read in conjunction with Figure 1.1, which illustrates the hierarchical structure of courts in Australia.

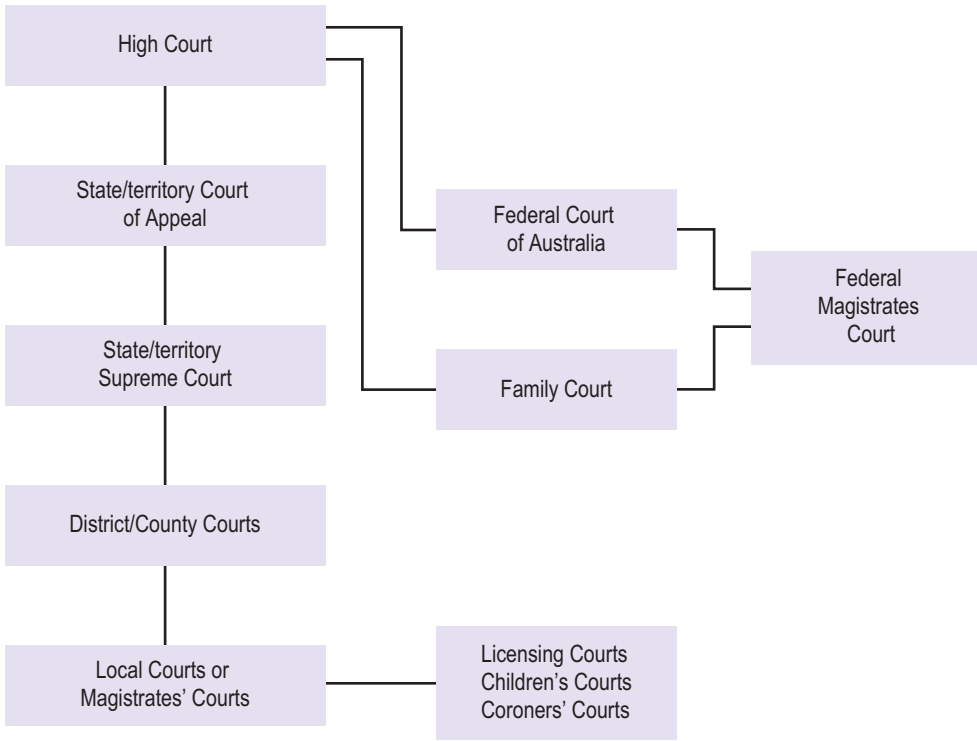


Figure 1.1 Hierarchical structure of courts in Australia

State and territory courts

LOCAL COURTS OR MAGISTRATES' COURTS

The *Local Courts Act 1982* (NSW) formally created the Local Courts, and changed the title of Magistrates' Courts from Courts of Petty Sessions to the Local Courts of New South Wales. In the other states and territories, such courts continue to be known as Magistrates' Courts.

These courts are at the bottom of the legal hierarchy, but undoubtedly deal with the greatest number of matters. They are presided over by magistrates, who are legally trained and qualified. Even tiny country towns have sittings of the Magistrates' Courts and, in big cities, Magistrates' Courts are located in many suburbs.

In carrying out their task, magistrates sit without a jury and can deal with criminal matters and civil matters, including some family law matters. However, the magistrates can deal only with those matters they have the power (jurisdiction) to deal with. In general terms, magistrates can deal with civil matters where the amount claimed by way of damages does not exceed the amount determined by the relevant legislation. In most states and territories that amount is $60 000 with some provision for extending that in relation to money claims excluding personal injury cases.

In South Australia the jurisdictional limit is $80 000 and in the Northern Territory it is $100 000. In criminal matters, magistrates deal with a wide range of criminal offences. Not surprisingly, such offences constitute the bulk of crimes committed in the community. The magistrates' powers to punish are limited to the type of offences with which they deal. One extension of their role in criminal matters is that, in relation to serious criminal offences which they do not have the power to deal with to finality, they do have the job of deciding if there is sufficient evidence to establish a prima facie case against the accused; that is, based on first impressions and from a consideration of the evidence, whether there is sufficient evidence to show that a jury is likely to find the accused guilty. If they so decide, the accused is then sent for trial before a higher court. Such proceedings are known as *committal proceedings*. In some states now, that initial committal process has been significantly truncated — instead of having an extensive preliminary hearing at the committal stage, the prosecution simply tenders the statements from those persons they wish to call at trial. Witnesses may or may not be called at that stage. Whatever procedure is observed from state to state and territory, the magistrate is still required to formally commit the accused to stand trial.

Magistrates also preside over a range of other courts; for example, Licensing Courts, Coroners' Courts, Children's Courts and Fair Rent Tribunals. Of all of those subsidiary courts, the Coroner's Court is most relevant to nursing staff. The role of the Coroner's Court is dealt with in more detail in Chapter 9.

DISTRICT OR COUNTY COURTS

The next tier in the hierarchy of the court and judicial system is generally known by the name of the District or County Court, depending on the state or territory in which the court is located. In New South Wales, Queensland, South Australia and Western Australia it is known as the District Court whereas in Victoria it is called the County Court.

Because of their relatively small size or population, the Australian Capital Territory, the Northern Territory and Tasmania do not have this intermediate step of a District or County Court and rely on the Magistrates' Courts and the Supreme Court to cover the criminal and civil jurisdiction of the state or territory.

Sittings of this court are presided over by a judge appointed from the legal profession and, in carrying out the task, the judge sits with a jury in all criminal matters, but generally sits alone in civil matters. The role of the jury in criminal matters is to decide on the guilt or innocence of the accused. The role of the judge in criminal matters is to decide questions of law, direct the jury on relevant points of law that arise, and punish the accused when, and if, he or she is convicted. Juries are not routinely used in all civil matters. When they are, their role is to decide the issue in dispute and, if decided in favour of the plaintiff, to generally determine the amount of compensation to be awarded.

The role of the District or County Court judge is divided into civil and criminal sections and, like the Magistrates' Courts, there is a limit placed on the jurisdiction of these courts to deal with such matters. While there are variations between the states, in New South Wales, for example, the jurisdiction of the District Court to

deal with civil matters is limited to those matters where the amount claimed by way of damages does not exceed $750 000 and is unlimited in relation to motor vehicle injury claims. In criminal matters this court deals with all major criminal offences with the exception of the capital offence of murder. In other states and territories the civil and criminal jurisdiction of this court does vary. The power of this court to punish extends to the penalties provided for the offences it has to deal with. Judges of this court sit daily in the capital and large country cities and travel 'on circuit' to smaller country towns for a week or two at regular intervals. Judges of this court can also hear appeals from a decision of a magistrate in certain matters.

STATE AND TERRITORY SUPREME COURTS

All states and territories have a Supreme Court. It is the highest or most senior court in the judicial system within state and territory boundaries. Sittings of this court are presided over by judges appointed from the legal profession and, in carrying out their task, they sit with a jury in the same circumstances as judges in the District or County Courts. The role of this court is divided into civil and criminal sections. This court has unlimited financial jurisdiction in civil matters and its criminal role is generally confined, as a matter of practice, to dealing with the capital offences of murder and serious sexual offences.

Like the District or County Court judges, judges of this court sit daily in the capital cities. There are regular sittings of the court in major country towns, which are presided over by the judges travelling 'on circuit' in the same way as the District Court judges do.

One of the additional tasks of the Supreme Court is to hear appeals from the lower courts and from decisions of a single judge of the Supreme Court. To do this a Court of Appeal has been established within the Supreme Court and is presided over by at least three judges of appeal. Once again the appellate role of the Supreme Court is divided into civil and criminal sections.

Federal courts

FEDERAL MAGISTRATES COURT

The Federal Magistrates Court was created by the Commonwealth Parliament in 1999 by the enactment of the *Federal Magistrates Act 1999*. The court was created in response to the need to alleviate the large workloads of the Federal Court and the Family Court. As such, the Federal Magistrates Court shares concurrent jurisdiction with the Federal Court and the Family Court over the following areas of law:

- family law and child support;
- administrative law;
- bankruptcy;
- unlawful discrimination;
- consumer protection and trade practices;
- privacy law;
- migration;

- copyright;
- industrial law;
- admiralty law.

The Federal Magistrates Court does not deal with criminal matters. Although the court shares concurrent jurisdiction with the Federal Court and the Family Court, its jurisdiction is limited in certain areas. For example, it does not have the power to deal with adoption and applications concerning nullity or validity of marriage under its family law jurisdiction.

Appeals from final decisions of federal magistrates are available as a right to appeal to the Full Court of the Federal Court or the Family Court, depending on the jurisdiction exercised by the court.

FAMILY COURT OF AUSTRALIA

This court was created by the Commonwealth Parliament in 1975 by the enactment of the *Family Law Act 1975* to deal with issues arising in relation to marriage, the dissolution of marriage, children and property rights. Within the Family Court structure, there is provision for an appeal court of three judges known as the Full Court of the Family Court. That court hears and determines appeals from decisions of single judges of the court and from the Federal Magistrates Court. There is also an appeal right with leave from the Full Court of the Family Court to the High Court.

FEDERAL COURT OF AUSTRALIA

This court was created by the Commonwealth Parliament in 1976 by the enactment of the *Federal Court of Australia Act 1976*. The main reason for its creation was to relieve the High Court of its workload that arises from some of the exclusive constitutional powers of the Commonwealth; for example, trade practices, bankruptcy, immigration and federal industrial issues. There is also an appeal right with leave from the Federal Court to the High Court. Within the Federal Court structure, there is provision for an appeal court of three judges known as the Full Court of the Federal Court. That court hears and determines appeals from decisions of single judges of the court and from the Federal Magistrates Court.

HIGH COURT OF AUSTRALIA

This court was created by the *Commonwealth of Australia Constitution Act*, which has been previously referred to. The initial intent in creating the High Court was that it would deal with constitutional disputes that arose between the Commonwealth and the states and territories. In addition to its initiating role in dealing with constitutional matters, the role of the High Court as a senior and final court of appeal from state or territory Supreme Courts, as well as the Federal and Family Courts of Australia, has increased considerably to embrace civil and criminal matters. An appeal in such circumstances is not automatic, as the High Court must grant leave to appeal and will only do so if the matter to be appealed constitutes a point of law of general public importance.

For many years there was a right to seek leave to appeal from a decision of the High Court to the Privy Council in the United Kingdom, but this was abolished in 1975. The High Court of Australia is the final Court of Appeal in Australia on all matters.

Other court systems and tribunals

The structure that has been outlined is the basic and permanent court structure that exists in each of the states and territories as well as the Federal court system. Coexisting with those structures and feeding into them at various points, generally for appeal purposes, is a wide range of courts and tribunals dealing with specific matters; for example, industrial courts, workers compensation courts, land and environment courts, anti-discrimination and administrative appeal tribunals as well as professional disciplinary tribunals.

The appeal process

Generally speaking, there is nothing to prevent a person or party, who so wishes, from appealing against a decision of a magistrate to a higher court. Such an appeal may be based on a number of points; for example, that the magistrate erred on a point of law or that the punishment imposed was too severe or too lenient.

Likewise, the decision of a District Court judge or a single Supreme Court judge may also be appealed against to the appeal court of the state or territory Supreme Court on similar grounds. From there, an appeal may be made to the High Court of Australia, subject of course to leave being granted by the High Court.

The doctrine of precedent

The development in England of the King's law from the twelfth century onwards and the establishment of common-law principles saw the early beginnings of the *doctrine of precedent*. The King's judges (knights) took to making notes of their decisions in previously decided cases. When similar cases came before them, these notes would then be used as a precedent; that is, as a persuasive guide to assist the courts. Over the centuries this practice of convenience hardened and gradually developed into a rule of law known as the doctrine of precedent. As long ago as the early twentieth century, the concept of binding precedent had been established. It means that the decision of a superior court on a legal issue will bind a lower court when it is called upon to deal with the same legal issue in another matter. As an example, a magistrate would be bound to follow the decision of a Supreme Court judge who had handed down a decision on a particular legal issue if such an issue came before the magistrate. Likewise a judge in a District or County Court is bound by a decision of the Supreme Court of that judge's state or territory in a case involving the same legal issue. A decision of the High Court of Australia is binding on the Supreme Courts of the states and territories and on all courts below them. Apart from any other considerations, the doctrine of precedent brings a degree of order and certainty into what could otherwise be a chaotic situation for a potential litigant or any person brought before the courts.

In applying the principle behind the doctrine of precedent, what is important is that it is not the decision as a whole that is binding, but the major principle of law

enunciated by the decision. That major principle of law is known as the *ratio decidendi* of the decision and has to be extracted by a careful reading and analysis of the decision. In essence, the ratio decidendi of a case can be defined as the material facts of the case plus the decision made on those facts.[4] Any additional comments made in the decision that do not form part of the ratio decidendi of the decision are generally referred to as *obiter dicta* (things said in passing).

Apart from the binding precedent of court decisions within the individual state or territory and Commonwealth hierarchical court structures, the decisions of courts outside this structure that have English common-law origins can be used as persuasive precedents in our courts. As an example, decisions of the courts of New Zealand, Canada or the United States can be, and are, sometimes used in this fashion.

As well, Australia is a signatory, ratified by Federal Parliament, to a wide range of international legal treaties; for example, the International Declaration on the Rights of the Child. Where such a treaty exists to which Australia is a signatory and which is relevant to a particular area of the law before courts in Australia, reference can be made to such international documents to the extent that it assists in determining the law in Australia. Reference to such an international document to which Australia is a party would only be done to assist in interpreting the law as it currently applies in Australia, having regard to any federal, state or territory legislative or common-law principles applying.

Who pays the bill?

Generally speaking, unless legal aid is granted, any person coming before the courts in a criminal matter, or any person wishing to commence legal proceedings in a civil matter, bears the burden of paying their own legal expenses. There are exceptions and also some expensive complications to that rule.

In criminal matters and family law matters each party must pay their own legal bills and cannot be made, except in relatively unusual circumstances, to pay the legal expenses of the other party. As far as the rest of the civil law is concerned, the general principle is that the party who loses pays their own legal costs plus the costs of the successful party in accordance with a scale of fees approved by the court. Such a rule can have harsh consequences on the unsuccessful litigant and is an issue that bears careful consideration when embarking on any litigation. Entitlement to legal aid is means tested in all state, territory and Commonwealth matters and in most situations this effectively precludes the great majority of middle-income earners.

The next section will provide an understanding of the workings of criminal law. Although most nurses and midwives do not usually come into contact with criminal law in the course of their work, it is important to have a broad understanding of this aspect of the law in order to differentiate it clearly from the civil and administrative jurisdictions, which form the substance of this text.

Criminal law

As a general rule, it is hoped that a detailed knowledge of the criminal law does not arise for consideration in the day-to-day working activities of nurses and midwives.

The major area of interest for them, as far as their professional legal liability is concerned, are those parts of the civil law which have been canvassed in detail in this text. Nevertheless it is essential that every nurse and midwife should have a basic knowledge of the criminal law and its operation. In addition, an ability to distinguish between criminal law and civil law is necessary for a better understanding of the different principles and administrative systems involved. The major differences between the civil and criminal law processes and the ability for civil and criminal law proceedings to arise out of the one action are explained earlier in this chapter.

Development of the criminal law

As suggested above, the best way to think of the criminal law is essentially as a set of rules of behaviour backed up by the sanction of punishment which governs our conduct in the community having regard to other people and their property. These rules of behaviour dictate that certain activities are unlawful and, as such, constitute an offence against the state or territory and thus are deserving of punishment. The types of activities that are deemed to be criminal offences vary widely from the relatively minor offences created under motor traffic legislation, such as speeding or failing to keep a proper lookout, to the more major offences; for example, murder, sexual assault or armed robbery.

In determining certain activities as being contrary to established and acceptable standards of behaviour in the community, and therefore criminal offences, parliaments are influenced by prevailing community attitudes to the activity in question. Community attitudes are a combination of social mores with moral and religious influences as to what is right or wrong. As an example, homosexuality has a long history of being deemed to be a criminal offence (and it still is in certain circumstances in all states and territories), largely because of prevailing community attitudes to this activity. The views expressed from time to time by certain sections of the community advocating the decriminalisation of the use of marijuana is another example of an activity which is deemed to be a criminal offence deserving of punishment because of prevailing community attitudes.

As with the civil law, the Commonwealth and individual state and territory parliaments have supplemented the common-law principles relating to the criminal law by passing appropriate legislation. As an example, in New South Wales, motor traffic offences, including drink driving, are created pursuant to the *Road Transport (Safety and Traffic Management) Act 1999* of that state. Offences that arise in relation to the use, sale, supply and possession of drugs in New South Wales are created pursuant to the *Drug Misuse and Trafficking Act 1985* and the *Crimes Act 1900* of that state. The states of Queensland, Tasmania and Western Australia have incorporated their legislation in relation to the criminal law into comprehensive criminal codes whereas the other states and territories supplement the common-law principles with legislation as required.

The various governments delegate the authority to uphold the law to the police force of the state or territory. The major responsibility of any police force is to prevent criminal activity within the community in which it operates and to apprehend those persons who do participate in such activity. If a person is apprehended

or arrested for a criminal offence, the duty of the police in the first instance is to make inquiries and, depending on the result of those inquiries, then charge the person with the offence he or she is suspected of having committed. According to the nature and seriousness of the offence charged, the person charged (the accused) must be brought before the appropriate court. The person concerned may plead guilty to the charge, but if that person does not plead guilty, the police, on behalf of the state or territory, have the task of proving that the accused person committed the offence with which he or she is charged. A well-established presumption of the common law is the presumption of innocence; that is, a person is presumed innocent until proven guilty. The task of having to prove an accused person's guilt is known as having the *burden of proof*. In addition to having the burden of proving the accused person's guilt, the police must discharge that burden by producing evidence to achieve a particular standard of proof. In criminal matters, the standard of proof is *beyond reasonable doubt*; that is, there must be more than a reasonable doubt as to the accused person's presumed innocence. Alternatively, to look at it from the point of view of any explanation put by the accused, all that the accused has to do to rebut the police evidence is to raise a reasonable doubt as to his or her guilt.

According to the nature and seriousness of the offence charged, the evidence will be presented before a magistrate or a judge and jury, who will have the task, on the basis of the evidence, of deciding the guilt or innocence of the accused. If the accused is found guilty of the offence, or has pleaded guilty, he or she is then deemed to have been convicted of the offence and will be punished by the magistrate or judge. The punishment imposed will depend on such factors as the nature of the offence, the maximum penalty imposed by the relevant legislation and the previous good character or otherwise of the convicted person. The power of the courts to punish people ranges from the imposition of a fine to long-term imprisonment.

In general, criminal offences can be divided for administrative purposes into major and minor offences. Major criminal offences were originally termed *felonies* and minor offences, *misdemeanours*. Such distinctions are now termed *indictable offences* and *summary offences* respectively. Indictable offences are the more serious offences against persons and property — for example, murder, armed robbery, aggravated sexual assault — whereas summary offences are the less serious offences, such as motor traffic offences, shoplifting or minor drug offences.

The elements of a crime

In order to establish that a person committed a criminal offence, two essential elements must be shown to exist:

1) the activity that constitutes the offence;
2) the intention to carry out the activity or a high degree of reckless indifference as to the probable outcome of a particular activity.

The first element is often referred to as the *actus reus* of the offence; that is, the activity that constitutes the offence. For example, in a charge of theft the 'activity' of the offence would be the dishonest appropriation of property belonging to

another person without that person's consent, and in a charge of assault the 'activity' of the offence would be the application or threatened application of a blow or force or the touching of another person without the other person's consent.

The second element is often referred to as the *mens rea* of the offence; that is, the guilty mind, where there is the intention to carry out the activity, or in some instances a high degree of reckless indifference as to the probable outcome of a particular activity. As a general rule, if the activity is carried out without the necessary intention there can be no crime. Such a proposition is expressed in the legal maxim: *actus non facit reum nisi mens sit rea* (activity does not produce a criminal unless there is a guilty mind). In the charge of theft, the 'intent' element of the offence would be the intention to permanently deprive the owner of his or her property. Accordingly, the 'activity' and 'intent' elements of the offence of theft, when expressed together, would be the dishonest appropriation of property belonging to another without consent with the intention of permanently depriving that person of the property.

In the charge of assault, the intent would be to inflict bodily harm on a person or, in some situations, a reckless indifference as to the likelihood of harm occurring. The following is an example of the element of reckless indifference. Two schoolboys, both aged 15, pushed a paving stone over the parapet of a railway bridge onto an approaching train. The paving stone crashed through the glass window of the train driver's cab, striking the guard and killing him. They were charged and subsequently convicted of manslaughter. They appealed against the conviction but were unsuccessful. The appeal court stated:

> An accused was guilty of manslaughter if it were proved that he had intentionally done an act which was unlawful and dangerous and that the act had inadvertently caused death … In judging whether the act of the accused was dangerous, the test was not whether the accused himself recognised the act to be dangerous but whether sober and reasonable people would recognise its danger.[5]

Criminal negligence and the significance of the element of intent in healthcare settings

On occasions, incidents may occur in hospitals or healthcare centres that, at first glance, suggest a criminal offence has been committed. For example, if a patient died as a result of the administration of a wrong drug it might be thought that whoever administered the drug was guilty of murder or manslaughter. However, as far as the criminal law is concerned, the most significant factor to be established would be the presence or otherwise of any intent to cause harm or a high degree of recklessness or inadvertence such as to amount to criminal negligence. If the wrong drug were administered intentionally, with the deliberate intent to kill the patient, this would amount to murder. If the drug were given believing it to be the right drug but with an attitude or degree of recklessness as to the amount to be given or the contraindications to be observed in the administration of the drug and the patient died as a result, this may amount to the offence of manslaughter on the basis of criminal negligence. In most situations in hospitals where mistakes are

made, what is usually present is a degree of carelessness or error of judgment such as to amount to civil negligence. For a nurse or midwife to be found guilty of criminal negligence as a result of their activities at work, there has to be a much higher degree of negligence, which would demonstrate an attitude of recklessness or inadvertence to the possibility of harm occurring.

It is essential to distinguish between civil negligence and criminal negligence. One of the earliest cases that clearly made that distinction concerned the actions of a doctor in attending a woman during delivery. The English case is reported as *R v Bateman*.[6] The relevant facts are set out below.

Dr Bateman attended a woman at home during labour. The labour was prolonged and the child's presentation was unusual and difficult. The doctor attempted to turn the child by the procedure known as 'version'. In doing so, he used considerable force over a period of an hour and delivered the child, which was dead. In delivering the placenta he also removed, by mistake, a portion of the patient's uterus. After the delivery the doctor left the patient at home. Five days later the patient was so ill the doctor then transferred her to hospital where she died two days later. The post-mortem examination revealed the following:

> … the bladder was found to be ruptured, the colon was crushed against the sacral promontory, there was a rupture of the rectum and the uterus was almost entirely gone.[7]

Dr Bateman was charged with manslaughter on the grounds of criminal negligence in that he had:

- caused the internal ruptures in performing the operation of version;
- removed part of the uterus along with the placenta;
- delayed sending the patient to hospital.

The doctor was found guilty of manslaughter on the grounds of criminal negligence. He appealed and his conviction was quashed. In handing down their decision the judges of the Court of Criminal Appeal stated, in part:

> To support an indictment for manslaughter the prosecution must prove the matters necessary to establish civil liability (except pecuniary loss) and, in addition, must satisfy the jury that the negligence or incompetence of the accused went beyond a mere matter of compensation and showed such disregard for the life and safety of others as to amount to a crime against the State and conduct deserving of punishment … there is a difference in kind between negligence which gives a right to compensation and the negligence which is a crime.[8]

The test established here is of general application in Australian courts and has been applied and approved in other English cases when considering the issue of criminal negligence (*Andrews v DPP*; *Akerele v R*).[9] It would be a rare case where a nurse or midwife, or any other health personnel for that matter, showed such a disregard for the life and safety of others as to constitute criminal negligence.

As an extreme example of such a situation, suppose that a patient, Mr Smith, was ordered to have a number of units of blood following major surgery. The appropriate cross-matching had been done and the cross-match slip was received in the ward. When one of Mr Smith's units was complete, Miss Jones, a registered nurse, went out to the refrigerator where cross-matched blood for all of the patients in the hospital was kept. Miss Jones picked up the first bag of blood she saw and did not bother to check it against any slip or with any other person. She came back to the ward and then proceeded to administer it to Mr Smith. The blood was incompatible; Mr Smith nearly died and was extremely ill for many months. When questioned about her actions, Miss Jones admitted that she was aware of the dangers of incompatible blood transfusions and the need for checking but thought that on this one occasion it would be 'all right', and that nothing would happen. She also said she was sorry about what had happened and had not really meant to hurt Mr Smith.

Extreme though this example may be, it illustrates the degree of negligence which must be present to constitute the requisite intent in a charge of criminal negligence occasioning grievous bodily harm. In New South Wales such an offence, if proved, carries a maximum penalty of ten years imprisonment. The other states and territories have similar provisions. If Mr Smith had died as a result of the incorrect blood transfusion, Miss Jones might well have faced a charge of manslaughter on the basis of the facts given.

The types of conduct that can amount to criminal negligence are infinitely variable and may or may not cause the death of another person. Where the conduct of a person causes the death of another and gives rise to a charge of criminal negligence, such criminal negligence is generally referred to as *involuntary manslaughter*.

It is worthwhile at this point to briefly distinguish between murder and manslaughter. Murder, or homicide as it is often known, is the killing of another person based predominantly on the intention to kill. Homicide is regarded as lawful if it is committed in the execution or advancement of justice such as a police officer shooting a person who prevents the police officer from carrying out his or her duty in certain circumstances.

Manslaughter is where a person is killed by another based not necessarily on having the intention to kill, but as a result of an unlawful or recklessly negligent act. Manslaughter is a crime which covers a diversity of unlawful killings which are not considered murder, generally because of the absence of a deliberate intent to kill. Obviously a charge of manslaughter could arise from a criminally negligent act if the patient died as a result. Manslaughter has also been described in a decision of the High Court of Australia (*R v Timbu Kolian*) thus:

> I think it is correct to say that by the common law today, an unintended, wholly unexpected and unlikely killing is manslaughter if, but only if, it be the result of some act which is both unlawful and in the circumstances dangerous, or is the result of some conduct amounting to reckless negligence.[10]

Manslaughter is generally divided into two types: voluntary and involuntary manslaughter.

Voluntary manslaughter is where the accused generally intended to kill but his or her liability for what would otherwise be a charge of murder is reduced because of such mitigating factors as provocation or self-defence.

Involuntary manslaughter is where the accused killed as a result of some unlawful and dangerous act, or a criminally negligent act, or where the accused intended to inflict bodily harm but did not intend to kill.

From these examples, it can be seen that the types of behaviours which fall within the criminal law usually fall (thankfully) outside the scope of practice of most nurses and midwives. However, it is the element of either intent or 'reckless negligence' which renders a harmful act criminal, and it is important to bear this in mind when thinking through ethical dilemmas.

Endnotes

1) *Commonwealth v Tasmania* (1983) 158 CLR 1; 46 ALR 625; 57 ALJR 450, commonly referred to as the *Tasmanian dams case*.
2) *New South Wales v Commonwealth* [2006] HCA 52 (14 November 2006), commonly referred to as the *WorkChoices amendments case*.
3) Williams G, *Learning the Law*, 10th ed, Stevens, London, 1979, p 2.
4) Ibid, p 62.
5) *DPP v Newbury and Jones* (1976) 2 All ER 365.
6) *R v Bateman* (1925) All ER 45.
7) Ibid, at 47.
8) Ibid, at 49, 51.
9) *Andrews v DPP* (1937) AC 576; *Akerele v R* (1943) AC 255.
10) *R v Timbu Kolian* (1969) ALR 143, per Windeyer J at 151.

This page intentionally left blank

Chapter 2

The relationship between law and ethics

Perhaps the best way to provide an explanation of the relationship between law and ethics is to use a personal example. If you were told you needed to have an operation there would be a number of concerns you would wish to have addressed. You would want to be informed adequately about the nature and consequences of the surgery so that you would be able to make a wise choice. You would want to know that the surgeon and anaesthetist are competent, that the nursing staff are competent and will care for you in a compassionate manner, and that the private information you choose to share with the nursing and medical staff will be treated confidentially and not discussed inappropriately. For each of these concerns to be addressed properly the nursing and medical staff who care for you will be required to behave in what would probably be described as a professional manner — and, in the majority of cases, this is indeed how nursing and medical staff do behave.

All of the above professional behaviours are ethical behaviours — they comply with established ethical principles and theories. Nurses, midwives and doctors normally behave in these ways because they wish to give the best possible care they can give to their patients. However, in Australia all of these behaviours are also legal requirements. That is to say, these behaviours are so fundamental to people's expectations of healthcare professionals that they have either been incorporated into the common law or enshrined in legislation. This need to provide for orderly and good conduct through the development of legal systems was discussed in Chapter 1. The major difference between these professional expectations being legal, as opposed to ethical, is that from a legal perspective, if these expectations are breached in some way, there will usually be some form of sanction or adverse consequence for the healthcare professional concerned.

However, sometimes the alliance between legal and ethical requirements is not as clear as in the above example. Not all laws are necessarily ethical — for historical examples, consider the laws governing slavery in America, the laws allowing persecution of the Jews in Nazi Germany, or the anti-apartheid laws in South Africa. Many people, believing strongly that these laws were unethical, did not comply with them and as a consequence put themselves at considerable personal risk. These are obviously extreme examples, but there are other scenarios where two or more possible

courses of action are available, each of which may be perfectly legal, but over which there may be disagreement as to the 'best' (for these purposes most ethical) course of action. Such situations may offer a range of alternative solutions, none of which will offer an ideal outcome. Consequently these will create ethical quandaries or dilemmas for the people involved.

However, it is important to recognise at this stage that there is more to making ethical decisions than simply adopting a moral stance, for example, according to strong religious or moral beliefs. Ethical decision-making is a complex and rigorous process, whereas our morality is what propels us to adopt a particular stance based on a particular set of beliefs, many of which have been inculcated into us since childhood. Johnstone, who argues that there is no philosophically significant difference between ethics and morality, nevertheless points out that:

> … while our 'ordinary moral apparatus' may motivate us and guide us to behave ethically as people, it is often quite inadequate to the task of guiding us to deal safely and effectively with the many complex ethical issues that arise in nursing and healthcare contexts.[1]

Ethics not only requires a consideration of morality but also many other factors, as will be seen later in this chapter.

Because of the human and complex nature of healthcare, ethical dilemmas are not uncommon in clinical practice and have received much attention in both academic and media circles over the past three decades. The study of ethical dilemmas in healthcare is often called 'bioethics'. There are many excellent and comprehensive texts available on the subject, a number of which are used as references in this chapter. Some of these ethical dilemmas have been major issues for society as a whole to ponder, such as resource allocation, euthanasia and gene technology, but other, more individual clinical dilemmas, such as telling patients the truth, challenging doctors about treatment choices and prioritisation of care, have also been reported by nurses and midwives as causing considerable angst.[2]

Making decisions about any of these ethical dilemmas is complex. Usually there are no simple answers; otherwise there would be no dilemma. However, it is possible to become skilled at ethical decision-making by developing and refining those decision-making processes and by being aware of the motives and values with which they are undertaken. Justice Michael Kirby made the observation that 'good law and good ethics must be grounded in good data'.[3] In analysing ethical dilemmas, the legal parameters of the situation are inevitably important aspects of the data, but are unlikely to be the only considerations. It is far beyond the scope of this chapter to provide a sound grounding in ethical decision-making or reasoning, but the chapter will set out some basic ideas about ethics and provide a range of sources, some practical, some more theoretical, to enable the reader to research the issues in more depth. To begin, the next section will attempt to define ethics and differentiate it from other concepts with which it is commonly confused.

Ethics: what it is

Kerridge, Lowe and Stewart state that 'ethics is the study of what we ought to do. Or if we restate this in the way of the Ancient Greeks, ethics asks each of us

"How should I live?"'.[4] Words like 'should' and 'ought' are often used in ethical discussion, but although they are helpful as a starting point, they are sometimes limiting, as such terms can also be applied to school rules and table manners. Kerridge et al. go on to provide a helpful amplification to this introduction by listing five general statements that can be applied to systems of ethics. These are as follows:

1) Ethics is broadly concerned with human flourishing and wellbeing and the construction and maintenance of a peaceful society in which all may benefit.
2) Ethics is prescriptive — it refers more to what we *should* do than what we actually do.
3) Ethics is a systematic approach that uses reason to define what ought or ought not to be done, either as action or process.
4) Ethics embodies ideas that are universalisable — so ethics is relevant to all individuals; and if we develop moral concepts, principles and action-guides, they should apply equitably to all persons equally.
5) Ethics is of overriding importance — that is, ethics is of greater significance than the law, politics or self-interest (although in practice ethics is often overridden by considerations of law, politics or self-interest).[5]

It is this systematic approach to addressing problems that is probably the most important aspect of ethics for nurses and midwives who are commencing on a path of ethical inquiry and study. Herring notes that:

> … ethical approaches to medicine (sic) must be practical. They must develop ways of reaching decisions about complex issues which can be used by medical (sic) professionals …While therefore it might be unreasonable to turn to medical ethicists to produce the 'correct' answer, it may be reasonable to expect assistance in thinking through the issues with sensitivity, logic and clear-headedness.[6]

Perhaps it would be fair to say that ethical decision-making is as much about asking questions as it is about finding answers. Clearly, the process of making careful ethical decisions takes time, yet often nurses and midwives are confronted with ethical dilemmas in the course of their working day and may have little opportunity to consider their immediate response. That is why the academic study of ethics is so helpful to nurses and midwives, as it enables them to explore in advance issues that might arise regularly and to develop at least some rudimentary decision-making skills. However, junior clinicians are always advised to discuss ethical dilemmas with more senior, experienced colleagues or other clinicians who may have more expertise in this area.

Singer, in his seminal text *Practical Ethics*, makes the point that ethics is fundamentally a practical concern.[7] It is concerned with making decisions and taking (or not taking) actions. Johnstone offers the idea of 'the task of ethics' which she says is 'to find a way to motivate moral behaviour, to settle disagreements and controversies between people, and to generally bind people together in a peaceable

community'.[8] Both undergraduate and some specialist postgraduate programs now contain the study of ethics within their curricula, which provide nurses with opportunities to hone and practise these skills away from the immediacy of the clinical environment.

Ethics: what it is not

Charlesworth points out a major problem — that ethical discussions often take place:

> … between people with widely differing interpretations of what the terms of the discussion mean, how the facts may be interpreted or described, and also with differing ethical stances.[9]

For this reason it is helpful to differentiate ethics from a range of other issues with which it is often confused. This enables nurses and midwives to look at what other value systems and ideas they might bring to any ethical decision-making process and be explicit about identifying them. In differentiating ethics, it also needs to be recognised that all of these factors are likely to be involved in and inform ethical decision-making. Although the famous bioethicist Peter Singer[10] was probably one of the first to embrace this differentiation approach, a number of other authors on health law and ethics have adopted it in recent times.[11] These other issues are listed below and then an example is used to explore each issue.

- Ethics is not a professional code of ethics nor a set of guidelines that, if followed, will lead to correct behaviour.
- Ethics is not professional etiquette or opinion.
- Ethics is not hospital policy or medical authority.
- Ethics is not religion or morality.
- Ethics is not law.
- Ethics is not gut feeling or intuition.
- Ethics is not empirical data.
- Ethics is not public opinion or consensus.
- Ethics is not following the orders of a supervisor or manager.[12]

An example of an ethical problem

Consider the following case study.

Mr X, an 89-year-old man, has been admitted in extreme pain with urinary retention. He has prostate cancer with multiple secondaries throughout his abdomen. He is middle European in origin and has limited English. His distraught wife and two sons are with him — both sons speak fluent English. Effective analgesia has been provided and he is sleeping when the surgeon arrives to see him.

The surgeon speaks with the sons and explains that the situation is terminal and that only palliative surgical measures will be undertaken to relieve his symptoms. The sons request that their father not be given his diagnosis. They explain that culturally it is the role of the family to be the decision-makers during illness and

that their father would not expect to be involved. Furthermore, they all believe it would be detrimental to their father's wellbeing for him to be given a terminal diagnosis.

The surgeon reluctantly accedes to this request because the sons are so adamant about their cultural practices. He simply tells Mr X that they will insert a suprapubic catheter later that day 'to bypass your blockage and sort out your pain'. However, when you are caring for Mr X during that day, he constantly asks you, in his limited English, whether or not he is dying. How would you deal with this situation?

HOW MIGHT THE NURSE RESPOND?

Clearly this is a difficult situation, and requires skilful and careful ethical decision-making. It may well be that you have already had an immediate reaction to this scenario — a *gut feeling* as to what *ought* to be done. You may have strong *religious* or *moral* convictions, and believe that your only option would be to answer Mr X truthfully that he is dying. You may already have found yourself taking 'sides' in this situation, believing that the *consensus/cultural* view taken by the surgeon and the sons was 'wrong'. Conversely, you may feel that the surgeon is in charge; he has made the decision and *professional etiquette* demands that you do not challenge him.

The *law* here is clear. Mr X has a legal right to be informed of all material risks relating to his treatment options (see *Rogers v Whitaker*).[13] Such a right would require him to be aware of his diagnosis in order to evaluate the treatment options before him. The *hospital policy*, particularly in relation to consent for surgical treatment, would mirror the law and would undoubtedly state that Mr X must be informed of his diagnosis and treatment options. Your immediate response might be to wish to comply with the law and hospital policy in disregard of the family's wishes and advise Mr X of his diagnosis. Only 'therapeutic privilege' would permit the surgeon not to inform Mr X fully about his surgery, and this limited defence can be exercised if either the patient expressly states that he or she does not wish to know (in which case it would be the patient's choice), or if the surgeon believed the information would be likely to cause serious physical or psychological harm to the patient.[14] The surgeon has conceded 'reluctantly' to the family's request and would probably consider the scenario does stretch the ambit of therapeutic privilege. However, a decision not to advise the patient may cause significant ethical distress for you, even if you decide to *follow the orders of your manager* and not provide information to the patient. Thus it can be seen that clinical decisions may be made for a range of reasons, not all of which may conform to the healthcare professional's sense of what is ethically appropriate.[15]

If you were to consult your Nursing and Midwifery Board of Australia (NMBA) *Code of Ethics for Nurses in Australia*, you might feel that it offered conflicting advice.[16] For example, Value Statement 3 states: 'Nurses value the diversity of people'. The explanatory statements in relation to both patients and communities accompanying that value statement (*inter alia*) advise that:

> Valuing the diversity of people requires nurses to appreciate how different cultural backgrounds and languages may influence both the provision and receipt of nursing and health care.
>
> …
>
> 2. *Person (health consumer)*: Valuing the diversity of people involves acknowledging and responding to each person as a unique individual, and to their culture. It requires nurses to develop cultural knowledge and awareness and greater responsiveness to the languages spoken enabling them to better understand and respond effectively to the cultural and communication needs of people in their care, their families and communities during a health care encounter.
>
> …
>
> 4. *Community*: Nurses recognise and accept the diversity of people constituting the Australian community and that different groups may live their lives in ways informed by different cultural values, beliefs, practices and experiences. Nurses seek to eliminate disparities in nursing and health care, especially among population groups in society that are considered most vulnerable, including Aboriginal and Torres Strait Islander populations; asylum seekers, refugees and migrants; and ethnic, religious, national and racial minorities. Nurses work to reduce the adverse effects power imbalances and prejudicial attitudes and practices have on social and institutional justice, and on the just and humane provision and delivery of nursing and health care. In particular, they work to ensure people are not disadvantaged or harmed because of their appearance, language, culture, religion, age, sexuality, national or social origin, economic or political status, physical or mental disability, health status, or any other characteristics that may be used by others to reduce the equal enjoyment or exercise of the right to health.

However, Value Statement 5 of the *Code of Ethics* states: 'Nurses value informed decision-making'. The explanatory statements in relation to this value statement include advice that:

> Nurses value people's interests in making free and informed decisions. This includes people having the opportunity to verify the meaning and implication of information being given to them when making decisions about their nursing and health care. Nurses also recognise that making decisions is sometimes constrained by circumstances beyond individual control and that there may be circumstances where informed decision making cannot always be fully realised.
>
> …
>
> 2. *Person (health consumer)*: Nurses value the legal and moral right of people, including children, to participate whenever possible in decision making concerning their nursing and health care and treatment, and assist them to

> determine their care on the basis of informed decision making. This may involve ensuring people who do not speak English have access to a qualified health interpreter. Nurses recognise and respect the rights of people to engage in shared decision making when consenting to care and treatment. Nurses also value the contribution made by persons whose decision making may be restricted because of incapacity, disability or other factors, including legal constraints. Nurses are knowledgeable about such circumstances and in facilitating the role of family members, partners, friends and others in contributing to decision-making processes.

You might wonder how you can reconcile the respect for cultural practices with the right to information, particularly when both of these values are considered to be ethical behaviours expected of a nurse. This contradiction does not negate the value of a code of ethics, even though it clearly demonstrates why a code of ethics cannot be a manual for ethical behaviour. Rather, the code will assist you to identify the ethical issues involved in your dilemma so that you can then address them and, if necessary, make a choice between them.

You will remember that Michael Kirby stated that 'good ethics must be grounded in good data' and all the responses and pieces of information discussed above will form part of your ethical decision-making process.[17] However, having all the *empirical data* before you will not ultimately provide you with the reason to make this decision. For example, there may be pieces of information you choose to reject — possibly you may decide that the family will suffer immeasurably if the father is told the truth, despite the fact that you discover he really wants to know. But you still need to recognise that the family members are present in your thought processes and acknowledge the influence they will have on your decision. When you make an ethical decision, it will be necessary to justify both ethical actions in terms of ethical purposes and also the ethical purposes themselves.[18] Thus the questions you ask and the discussions you have with the key participants in this scenario will determine the quality of the decision you eventually make.

What resources are available to assist nurses and midwives to address such dilemmas?

As already noted, all of the above pieces of information discussed as part of the nurse's immediate response will be critical to the nurse's decision-making process and will inform that decision. The nurse needs to know what the law says, and what the hospital policy states. The nurse will be assisted greatly by being cognisant of the value statements in the NMBA *Code of Ethics* and any other codes of ethics or conduct which might bear upon nurses' practice (for example, some health departments also have codes of ethics and/or conduct). The nurse's own religious or moral convictions may influence the way he or she feels about whatever decision is finally made, even if the outcome is that the nurse opts not to be involved in the management of this problem. However, in order to obtain 'good data' and to 'justify the decision' the nurse does need to ask more questions and have further discussions with all parties involved in the situation. Furthermore, even a basic understanding of ethical theories and principles will assist the nurse to make better decisions.

However, people don't usually make ethical decisions based on theories alone. Some very useful practical skills which are essential for ethical decision-making are listening skills, communication skills, and the ability to trust ourselves and to value our own experiences, although not to the exclusion of those of our peers. We also need to be aware of the influence of power relationships on our ethical decisions. As nurses, we often imagine that we are powerless in clinical situations, but frequently it is the patient who is the least powerful participant.[19] It is important to recognise that the danger of privileging such an important process as ethical decision-making to the sole domain of healthcare professionals is that there is the risk that the process can disempower the very group it set out to assist.

There are numerous texts available which describe ethical theories and principles and offer models for ethical decision-making. Rather than provide a comprehensive account of these, the purpose of this chapter is to assist nurses to understand the relationship between law and ethics. Thus, the remainder of it will only highlight major ethical theories, principles and models for ethical decision-making, and recommend useful resources for further reading.

Major ethical theories

The study of ethics, of determining 'what ought to be done', has been around since the time of the Ancient Greeks and their ways of examining ethical behaviour provide the foundations for the two main branches of study of ethical theory — deontology and teleology. Other theories have developed in more recent times, such as feminist moral theories, and these are considered by some ethicists to be more appropriate to the caring professions. Both Johnstone and Kerridge et al. provide readable discussions on the different schools of thought in relation to these theories and their relevance to healthcare. All of these theories in their most extreme application can be controversial, and Johnstone recounts a number of concerns that have been expressed about traditional moral theories and principles.[20] However, one of the most useful aspects of learning about ethical theories for ethical decision-making is that nurses are able to identify the sources of the differing arguments being put forward by key players — it helps nurses to work out 'where (ethically) a person is coming from'.

Deontological or intrinsicalist theories

Deontological theories are sometimes known as 'intrinsicalist' theories because they propose the view that actions are intrinsically right or wrong in themselves, and thus the way to determine what one ought to do is guided by the action itself. For example, if a nurse believed that telling the truth was intrinsically right, then that nurse's view as to the correct action in our scenario would be determined according to that belief. Similarly, if a nurse believed that taking a person's life was intrinsically wrong, then that nurse's position in any debate about euthanasia would be clear.

Kerridge et al. point out:

> … the value of deontological theory is that it reminds us of the importance of rationality in moral judgment and of moral standards, independent of

> consequences. It has tremendous appeal for those who seek certainties in life and for institutions (such as the church or government) who have a need to bind together groups of people under some identifiable moral code.[21]

Indeed, deontological positions are more likely to be held by people with strong religious beliefs.

Teleological or consequentialist theories

Teleological theories are sometimes known as 'consequentialist' theories because an action is not necessarily considered to be morally right or wrong in and of itself, but rather is judged to be morally appropriate because of the consequences its position produces. The best-known branch of the teleological theories is known as utilitarianism, which is popularly described as an attempt to obtain 'the greatest good for the greatest number'. Taken to extremes, of course these theories can have bizarre outcomes. Nurses will find that such theories are often invoked in discussions about healthcare resource allocation. However, they usually arrive at an individual level for healthcare professionals when faced with a particular patient who would be disadvantaged by resource restrictions.

Kerridge et al. describe the value of consequentialism as reminding us 'that the consequences of our actions have moral significance and must be taken into account in the evaluation of actions and situations'. They go on to point out that:

> Consequentialism at least attempts to develop a rational process of moral reasoning that enables the resolution of moral conflict, although in the end it probably does not succeed. Finally, consequentialism attributes moral worth to specific situations or contexts in a manner that has immediate intuitive and clinical appeal, even for those who profess the central importance of rules.[22]

Modern feminist ethics

Modern feminist ethics has come to the fore with the rise of the feminist movement over the past three decades. Fundamentally modern feminist ethicists criticise traditional ethical theories for disregarding both the contribution of women to ethical debate and the needs of women in ethical debate, particularly in relation to ethics of care and ethics of interpersonal relationships. Feminist ethicists (*inter alia*) have challenged why such moral attributes as reason, which has been revered by philosophers over the centuries, should be given supremacy over such attributes as empathy, compassion, sympathy or caring in moral decision-making and thinking. Kerridge et al. helpfully identify a number of characteristics in feminist philosophies, namely that they:

a) reject the overemphasis on individual rights, autonomy and rationality in bioethics (Parsons, 1986);
b) deny the requirement for value-neutral philosophies or abstract ethical principles (Harding, 1991);
c) reject the adversarial nature of moral conflict as a means for resolving ethical issues in clinical practice;

d) stress the significance of values such as empathy, interdependence and caring, and the importance all members of society have to each other; and
e) emphasise the importance of context and the relevance of politics and power to understanding ethics and healthcare.[23]

Other ethical theories and concepts include rights-based theories, virtue ethics, discourse ethics and narrative ethics, all of which are accessibly covered to varying depths in either Johnstone or Kerridge et al. Kerridge et al. provide an excellent critique of nursing and nursing ethics but overall reject the notion of a specific ethics of nursing in favour of incorporating that which is best in the nursing ethics discourse into the wider healthcare discourse.[24] Johnstone, on the other hand, argues that nursing ethics is 'inevitable'. She says that:

> So long as nurses interact with, and enter into professional caring relationships with other people, they will not be able to avoid or sidestep the 'distinctively nursing' experience of deciding and acting morally while in these relationships. It is in this respect, then, that nursing ethics can be said to be inevitable.[25]

Most bioethics texts recognise the inadequacy of ethical theories in their application to practical bioethics. However, these inconsistencies and differences probably reflect the real difficulties nurses have in ethical debate in clinical practice, where many competing imperatives will shape the dilemma, as seen in the case study above. Notwithstanding these criticisms of ethical theories, using theories, concepts and principles to inform our ethical thinking is of great importance if we are to improve our ethical practice as clinicians. Johnstone argues that one of the major moral problems nurses (and other healthcare professionals) encounter is that of 'moral unpreparedness'. She argues that such moral unpreparedness is analogous to and as unacceptable as clinical unpreparedness; for example, putting a clinically unprepared nurse in charge of a ventilated patient in intensive care.[26]

Perhaps more recognisable to clinicians than ethical theories are the four ethical principles identified by Beauchamp and Childress. These are widely accepted as valuable in bioethical decision-making and are discussed below.[27]

The four major ethical principles

The notion of a principle is that it is a rule or standard to be applied in any given situation. There is a sense in a principle that it is the right thing to do, that it will guide one's behaviour. The four ethical principles commonly used in bioethics are autonomy, beneficence, non-maleficence and justice. Just as with ethical theories, these principles are not without controversy and, as will be seen in the ensuing discussion, can also be in competition with one another in any given situation. But their usefulness as a means of examining ethical dilemmas is apparent from their popularity in models of bioethical decision-making.

AUTONOMY

Autonomy is commonly described as: the right to self-determination, the ability to control what happens to us and how we behave. This exercise of our own free will

is only acceptable if it does not adversely affect the rights of others. It is an important ethical principle as it involves respect for individuals and their personal space. It is also a principle which is reflected in a number of areas of health law, particularly in relation to one's right to consent to treatment and to receive information about one's treatment. However, this ethical principle is not upheld in law in every situation. For example, people do not have the right to exercise autonomy in relation to voluntary euthanasia, as it is illegal, nor do people have the right to be assisted to die at any time they may choose.

Nurses and midwives need to remember that, in order to exercise autonomy, it is often necessary to be assertive. It is not always easy for a patient to be assertive when they are 'at the mercy' of the nursing and medical staff, particularly if their exercise of autonomy would bring them into confrontation with those staff. Neither has it always been easy for nurses to be assertive, schooled as they have been in the past in the need for absolute obedience, particularly to the doctor.[28] Furthermore, the principle of autonomy is, as seen in the case study above, culturally a Western concept. Some other cultures do not think primarily in terms of autonomy and individualism, but rather in terms of interdependence and community, and yet the laws in Australia usually uphold the principle of autonomy.[29]

BENEFICENCE

Beneficence is often described as the principle of 'above all, do good'. This desire to do good is undoubtedly what motivates most healthcare practitioners. However, it is valuable to recognise that there are times when people's idea of what constitutes 'doing good' may go against the wishes of an individual; for example, when a patient is terminally ill and may be prepared to die, but the doctors and nurses cannot bear to cease treatment. One of the important questions to ask in situations relating to beneficence is: Whose good are we trying to serve? Kerridge et al. point out that if a patient's autonomy is overruled on grounds of beneficence, this is known as paternalism.[30] Beneficence and non-maleficence are often two sides of the same coin — but often the difficulty in practice is to work out where one ends and the other begins. For example, if a nurse is debriding burns or performing some other painful dressing for a patient, the nurse may well be causing the patient some discomfort (at least) which could be construed as 'doing harm' and yet the nurse's motives for undertaking the dressing or debridement are to 'do good'. In such a situation, it is clear that the nurse must debride the wound, yet the principles could be construed as being in conflict with one another.

NON-MALEFICENCE

Non-maleficence is the principle of 'above all, do no harm'. This is a very strong principle in healthcare and forms the basis of nurses' and midwives' duty to take care in the way in which they look after their patients. It can also be recognised in the 'duty of care' which is one of the elements of the tort of negligence. This obligation to do no harm is argued to override the principle of beneficence ('above all, do good'). Beauchamp and Childress argue that our duty to do no harm is greater than our duty to do good, particularly where our duty to do good may put others or ourselves at risk.[31]

JUSTICE

Justice has two meanings in ethics — justice as fairness and justice in terms of an equal distribution of burdens and benefits. Justice as fairness also has two interpretations: that of treating people equally and that of 'getting one's just desserts' — deserving what happened.

The principle of 'justice as fairness' implies and expects a level of impartiality and neutrality in dealings with others. However, treating people equally does not necessarily equate with treating people in the same way. Patients are not the same in terms of their social, educational and cultural backgrounds and nurses may need to adopt widely differing strategies to achieve equal treatment for two patients. For example, providing adequate information about a laparoscopic cholecystectomy for an elderly woman from a non-English speaking background may require very different strategies than providing the same information to a university-educated, English-speaking 45-year-old man. With these considerations in mind, justice as fairness is an important principle as it is the basis for the requirement to avoid discrimination against people who are different for whatever reason.

The second meaning of justice as an equal distribution of burdens and benefits is sometimes known as *distributive justice*. This principle is often used to address questions relating to resource allocation. The central tenet is that whoever we may be in society, the benefits and burdens would be equally shared between us. It is clear to see that this is not the case in modern society. This concept creates huge ethical difficulties for healthcare practitioners when they are required to apply the principle in practice. Questions arise such as: Which patients should receive treatment? If we close our mental institutions, how do we fund care in the community adequately? Such questions pose real dilemmas for healthcare practitioners, who have traditionally tended to operate in terms of individual patient relationships.

Models for ethical decision-making in healthcare

With these theories and principles in mind, a number of authors have suggested models to assist in ethical decision-making, some of which are more complex than others.[32] All adopt a problem-oriented approach to ethical decision-making. All involve a number of steps which include assessment, information gathering, planning or goal-setting (including weighing options) and implementing and evaluating the chosen plan. Kerridge et al. suggest that the legal parameters of the problem should be identified, as these will often dictate the course of action.[33] However, it may be that the issue is not so clear-cut, in which case a decision-making model may assist the individual to work through the ethical dilemma. All of the above authors provide useful decision-making models, but one of the more comprehensive ones is provided by Kerridge et al. and is reproduced in Figure 2.1 with their permission.

If this model were used to address the dilemma in the case study, it would clearly provide some useful pointers as to how to deal with the issue.

Clearly state the problem

How this problem is framed will depend upon what value systems the framer holds in the first place. But in anyone's language there seems to be a discrepancy between

A MODEL FOR ETHICAL DECISION-MAKING

Clearly state the problem:
Consider the problem within its context and attempt to distinguish between ethical problems and other medical, social, cultural, linguistic and legal issues. Explore the meaning of value-laden terms; for example, futility, quality of life.

Get the facts:
Find out as much as you can about the problem through history, examination and relevant investigations. Take the time to listen to the patient's narrative and understand their personal and cultural biography. Are there necessary facts that you do not have? If so, search for them.

Consider the fundamental ethical principles:
Autonomy: what is the patient's approach to the problem?
Beneficence: what benefits can be obtained for the patient?
Non-maleficence: what are the risks and how can they be avoided?
Justice: how are the interests of different parties to be balanced?
Confidentiality/privacy: what information is private and does confidentiality need to be limited or breached?
Veracity: has the patient and their family been honestly informed and is there any reason the patient cannot know the truth?

Consider how the problem would look from another perspective or using another theory:
Who are the relevant stakeholders? What is their interest? What do they have to lose?
How salient are their interests? How powerful are they? How legitimate are they? How urgent are they?
How would the problem look from an alternative ethical position? For example, consequentialist, rights-based, virtue-based, feminist, communitarian, care-based.

Identify ethical conflicts:
Explain why the conflicts occur and how they might be resolved.

Consider the law:
Identify relevant legal concepts and laws and how they might guide management.
Examine the relationship between the clinical–ethical decision and the law.

Make the ethical decision:
Clearly state the clinical–ethical decision and justify it; for example:

- identify ethically viable options
- make the decision and justify it; for example, by specifying how guiding principles were balanced and why
- take responsibility for the decision
- communicate the decision and assist relevant stakeholders to determine an action plan
- document the decision
- evaluate the decision.

Figure 2.1 Ethical decision-making model

Source: Reproduced from Kerridge I, Lowe M and McPhee J, Ethics and Law for the Health Professions 2e © The Federation Press, 2005 Sydney Australia, pp 84–5

what Mr X has been told about his condition and what he has a legal right to be told. Furthermore, what he has been told is not complete and he seems to be asking for more information. However, it will be important to ascertain linguistically that this is exactly what he is asking, as he has limited English and may be requiring a different outcome, such as reassurance, or even denial. We also know that the

surgeon is not happy about the situation but has 'reluctantly' agreed to the family's request on cultural grounds. However, little conversation has taken place between Mr X and the surgeon. It will also be necessary to factor in the impact on the family if a decision were made to inform Mr X of his diagnosis in contravention of the family's wishes. This problem raises cultural and legal issues as well as ethical issues and there are a number of people already involved in the case study — Mr X, his wife and sons, the surgeon, and you, at the very least.

Get the facts

There is much work to be done in relation to fact-finding in the case study. Further discussions are required with the surgeon and the family and with the other healthcare professionals involved in caring for Mr X, even including community carers, such as his general practitioner or community nurse. This is a critical time in the lives of Mr X and his family, and the hospital staff who are currently caring for him are probably the healthcare professionals who know him least well. Discussion is especially required with Mr X to ascertain what information he really wants to know. It may be advisable to use an interpreter rather than a family member to assist the surgeon and you in having these conversations with Mr X. However, at this stage you will need to be particularly aware that you and the interpreter are trying to find out all the facts, not institute solutions. Each conversation may lead to more information being required. It is most important to have all the information you need before you make any determinations about what ought to be done.

Consider the fundamental ethical principles

Autonomy: what is the patient's approach to the problem?

Beneficence: what benefits can be obtained for the patient?

Non-maleficence: what are the risks and how can they be avoided?

Justice: how are the interests of different parties to be balanced?

Confidentiality/privacy: what information is private and does confidentiality need to be limited or breached?

Veracity: has the patient and their family been honestly informed and is there any reason the patient cannot know the truth?

Your consideration of these principles will depend on what facts and information you have found. However, it seems clear that Mr X's wishes in regard to this situation must be balanced against the family's desire to 'do good' according to their culture and both your and the surgeon's desire to 'do no harm'.

The question of veracity, particularly from the patient's perspective, is highly significant here.

Consider how the problem would look from another perspective or using another theory

Questions about the key stakeholders are critical here, particularly as they will undoubtedly become clearer as further information emerges. You will also need to consider questions of power if your preferred ethical decision is in conflict with that

of other members of the healthcare team, especially if you are not in a position of authority. Rights-based ethics may move the decision in favour of advising Mr X, but conversely, if you determine that his relationship with his family is more important than his need to know his prognosis, an ethic of care may prevail.

Identify ethical conflicts

At first glance there do appear to be ethical conflicts between the need to enable Mr X to exercise autonomy by providing the information he seems to be seeking and the desire to 'do good' by respecting the cultural norms of him and his family. However, the need to 'do no harm' through avoiding any disharmony with the family dynamics is also critical. Other conflicts may also arise as you discover more information. On the other hand, it may transpire that when you have gathered all the information, these conflicts will resolve.

Consider the law

As already stated, the law is fairly clear in this situation. One question which has framed this ethical dilemma in the first place is whether or not the legal requirements for information giving and consent can be overridden either because of therapeutic privilege or cultural norms.

Make the ethical decision

Clearly state the clinical–ethical decision and justify it; for example:

- identify ethically viable options;
- specify how guiding principles were balanced and why;
- take responsibility for the decision;
- communicate the decision and assist relevant stakeholders to determine an action plan;
- document the decision.

Evaluate the decision

Whatever decision you finally make will be determined by the facts you discover in your decision-making process and the value you place on the differing pieces of information. Before you implement the decision, step once again through your justification, ensuring that your rationale is considered and robust. It may be that there is no consensus as to the best way forward, in which case a decision will have to be made and any differing views ought to be documented. If your preferred decision is the one to be implemented, then it is critical that you take responsibility for the decision and manage the consequences of the decision, following through on both positive and negative outcomes. Any difficult decision will not produce perfect outcomes and it is vital that the impact of the decision is handled with care and compassion. Evaluation of the process as well as the outcome is essential, otherwise you will have learned little from the experience.

The opportunity to reflect on our most difficult dilemmas and the choices we made about them is always to be welcomed. However, it is important to recognise that real reflection, as opposed to post-hoc justification, can sometimes be painful.

We may honestly feel on reflection that we could have managed the situation better or made better decisions. But clinical–ethical decision-making is often made 'on the run' and, with the best will in the world, we will not always get it right. It is important to welcome the evaluation as a learning opportunity and to recognise the potential for improvement.

CONCLUSION

Law and ethics are not the same, although ethical decision-making will always involve a consideration of the law. In addition, good laws should arguably also be ethical laws, but as seen from the ethical theories and principles presented above, there may be disagreement about their morality depending on which ethical theory or principle is being promulgated. However, there are a number of desirable healthcare practices, such as the requirements for confidentiality and consent, respect for persons, and care, both in terms of compassion and rigour, which are both ethically sound and legally required. Freckleton and Petersen point out that 'the practice of good ethics should not only bolster professionalism but also protect patients' rights and reduce the need for legal intervention into healthcare'.[34] In addition, when the courts are presented with issues they have not previously dealt with, such as withdrawal of life support (*Airedale NHS Trust v Bland*), or the harvesting of spermatozoa from a posthumous donor (*R v Human Fertilisation and Embryology Authority, ex parte Blood*), they draw on ethical principles and theories to assist them in their deliberations.[35] This will become clear in some of the cases discussed later in this book, and the reader might find it interesting to examine the case law with a view to ascertaining which principles were being upheld.

It is clear from this brief chapter that all ethical theories and principles are not without difficulty in relation to their application to practice. However, the use of an ethical decision-making model can provide a useful structure to address the complex and often difficult dilemmas nurses and midwives meet in clinical practice. Yet it is also important for nurses and midwives to recognise that, even after they believe they have reached an appropriate ethical decision, the power differentials in healthcare may mean that their decision is not the decision of choice. This can be extremely frustrating for nurses and midwives and has been the subject of much discussion, particularly in relation to recruitment and retention.

Endnotes

Note: All links given below were last accessed on 20 January 2012.

1) Johnstone M-J, *Bioethics: A Nursing Perspective*, 5th ed, Churchill Livingstone, Sydney, 2008, p 28.
2) Bach V, Ploeg J and Black M, 'Nursing roles in end-of-life decision making in critical care settings', (2009) *Western Journal of Nursing Research* 31 (4) 496–512; Chiarella E M, *The Legal and Professional Status of Nursing*, Churchill Livingstone, Edinburgh, 2002; Hancock K, Clayton J, Parker S, Walder S, Butow P, Carrick S, Currow D, Ghersi D, Glare P, Hagerty R and Tattersall M, 'Truth-telling in discussing prognosis in advanced life-limiting illnesses: A systematic review', (2007) *Palliative Medicine* 21:507–17.
3) Kirby M, 'Bioethics and democracy — A fundamental question' in Charlesworth M,

Life, Death, Genes and Ethics — The 1989 Boyer Lectures, ABC Books, Sydney, 1989, p 3.

4) Kerridge I, Lowe M and Stewart C, *Ethics and Law for the Health Professions*, 3rd ed, Federation Press, Sydney, 2009, p 7.
5) Ibid, pp 1–2.
6) Herring J, *Medical Law and Ethics*, Oxford University Press, Oxford, 2006, p 18.
7) Singer P, *Practical Ethics*, Cambridge University Press, Cambridge, 2011.
8) Johnstone, op. cit., 2008, p 49.
9) Charlesworth M, *Life, Death, Genes and Ethics — The 1989 Boyer Lectures*, ABC Books, Sydney, 1989, p 23.
10) Singer, 2011, op. cit.
11) Kerridge et al., 2009, op. cit.; Johnstone, 2008, op. cit.
12) Kerridge I, McPhee J, Jordens C and Clark G, 'Moral frameworks in healthcare: An introduction to ethics' in Freckleton I and Petersen K (eds), *Disputes and Dilemmas in Health Law*, Federation Press, Sydney, 2006, p 18. See particularly Johnstone, 2008, op. cit., at pp 38–40 for an interesting discussion on codes of ethics.
13) *Rogers v Whitaker* (1992) 109 ALR 625.
14) *Consent to Treatment Policy for the Western Australian Health System*, 2nd ed, Western Australia Department of Health, Office of Safety and Quality in Health Care, Perth, 2009, p 16.
15) See Johnstone, 2008, op. cit., pp 36–38.
16) *Code of Ethics for Nurses in Australia*, Nursing and Midwifery Board of Australia (NMBA). Note there is a separate *Code of Ethics for Midwives in Australia*, also published by the NMBA, http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx#codeofethics.
17) Kirby, 1989, op. cit., p 3.
18) Husted J H and Husted G L, *Ethical Decision-making in Nursing and Health Care: The Symphonological Approach*, Springer Publishing Co., New York, 2008, p 41.
19) Ibid, pp 42–43.
20) Johnstone, 2008, op. cit., p 54 et seq.
21) Kerridge et al., 2009, op. cit., p 12.
22) Kerridge et al., 2009, op. cit., p 16.
23) Kerridge et al., 2009, op. cit., p 23.
24) Ibid, pp 184–8.
25) Johnstone, 2008, op. cit., p 34.
26) Ibid, pp 112–13.
27) Beauchamp T L and Childress J F, *Principles of Bioethics*, 5th ed, Oxford University Press, New York, 1996.
28) Chiarella, 2002, op. cit. See specifically Ch 6 and the discussion of the nurse as the doctor's handmaiden.
29) For an excellent discussion on transcultural ethics see Johnstone, 2008, op. cit., Ch 4, pp 88 et seq.
30) Kerridge et al., 2009, op. cit., p 88.
31) Beauchamp and Childress, 1996, op. cit.
32) Kerridge et al., 2009, op. cit.; Johnstone, 2008, op. cit.; Seedhouse D, *Values-based Decision-making for the Caring Professions*, Wiley, London, 2005.
33) Kerridge et al., 2009, op. cit., pp 94–95.
34) Freckleton I and Petersen K (eds), *Controversies in Health Law*, Federation Press, Sydney, 1999, p xxvii.
35) *Airedale NHS Trust v Bland* [1993] 2 WLR 316; *R v Human Fertilisation and Embryology Authority, ex parte Blood* [1997] 2 WLR 806.

This page intentionally left blank

Chapter 3

Professional negligence and vicarious liability

Negligence as part of the law of civil wrongs

As explained in Chapter 1, an understanding of how the law operates requires, in the first instance, that the distinction be made between the criminal and civil law. Once that has been done, it is then necessary to further divide the civil law into a number of different areas; for example, family law, workers compensation, industrial law and so on.

One of the most important areas of the civil law is known as the *law of civil wrongs*, sometimes known as the *law of torts*. There are a number of civil wrongs or torts, the most widely known being negligence. Two other examples of well-known civil wrongs are nuisance and defamation. The legal principles that apply in these areas are essentially the well-established common-law principles that have been developed by the courts over the centuries. In some instances, however, parliament has supplemented the common-law principles with legislation. As an example, the initial common-law principles relating to civil defamation have now been either supplemented or replaced by the passing of specific legislation (generally known as the *Defamation Act*) in each state or territory.

This chapter is concerned with examining the law in relation to professional negligence, or medical negligence as it is often referred to. This area of the law permits patients, the relatives of patients, or other persons, to bring claims against hospitals, health authorities, medical practitioners, nurses, midwives and other healthcare professionals seeking financial compensation as a result of an alleged negligent act that has caused damage and financial loss, as well as pain and suffering.

In a civil negligence claim, the party or parties bringing the claim for compensation are known as the plaintiffs and the party or parties defending the claim are known as defendants. The plaintiff bears the onus of proof and must establish his or her claim according to the standard of proof for civil law matters which is on the balance of probabilities.

Legislative changes affecting the law in relation to civil negligence and professional negligence in particular

In 2002, significant legislative changes were introduced in all states and territories that have impacted on the law applicable to civil negligence and professional negligence in particular.

The impetus for such wide-ranging legislative change in this area of the law arose predominantly as a result of increasing judicial and community concern at the way in which the law of negligence and consequent financial liability to pay compensation was being extended resulting in public liability insurance becoming economically unsustainable. As well, increasing insurance premiums for medical practitioners in the healthcare sector was reflected in the high cost of professional indemnity insurance, particularly for rural GPs providing obstetric services including the refusal of obstetricians to provide community-based services. These concerns were brought to a head by a crisis in the insurance industry in 2001. When that occurred, a review of insurance premiums and coverage by public liability insurers saw significant increases such that many professionals and community organisations were unable to obtain public liability insurance or could not afford the new premiums set by the insurance companies.

As a consequence of the above, both the Federal and state and territory governments considered legislative reform was required. The basis of much of that legislative reform was the report of the Panel of Eminent Persons set up by the Federal Government in 2002. That panel became known as the Ipp Committee after the Chair of the Panel, Justice David Ipp, a Justice of the New South Wales Court of Appeal. The task of the Ipp Committee was to undertake a principles-based review of the law of negligence. In undertaking that review, the Ipp Committee was asked, amongst other matters, to:

> … develop and evaluate options for a requirement that the standard of care in professional negligence matters (including medical negligence) accords with the generally accepted practice of the relevant profession at the time of the negligent act or omission …[1]

As a consequence of the recommendations arising from the Final Report of the Ipp Committee, as well as legislative initiatives undertaken by the states and territories, the law in relation to civil negligence and professional negligence in particular has been amended. The problem that has been created, however, is that the legislative changes that have been made by the states and territories arising from the Ipp Report and its recommendations have not been uniform. The states and territories enacted different recommendations of the report as well as introducing a number of their own legislative initiatives. The end result is somewhat of a legal minefield and it is important to be aware of the differences depending on the state or territory in which one is practising and how the particular provisions of that state or territory impact on considerations of professional negligence, particularly for healthcare professionals.

Notwithstanding those comments, the legislative changes in this area of the law have not altered the fundamental principles that must be established where a person wishes to sue another for monetary compensation, alleging negligence. What has changed in some respects is the legal test to be applied in establishing those principles and, in relation to aspects of monetary compensation being claimed, limits have been placed on amounts that may be awarded by the courts.

The title of the legislation introduced in each state and territory relevant to considerations of professional negligence following the release of the Ipp Report is set out in Table 3.1.

Table 3.1 Legislation relevant to a claim alleging professional negligence	
Australian Capital Territory	*Civil Law (Wrongs) Act 2002*
New South Wales	*Civil Liability Act 2002*
Northern Territory	*Personal Injuries (Liabilities and Damages) Act 2003*
Queensland	*Civil Liability Act 2003*
South Australia	*Civil Liability Act 1936*
Tasmania	*Civil Liability Act 2002*
Victoria	*Wrongs Act 1958*
Western Australia	*Civil Liability Act 2002*

As stated earlier, not all states and territories incorporated all of the recommendations of the Ipp Report in their legislative changes in the exact same terms and, as a result, differences of approach do apply between them. Only the more significant differences in relation to professional negligence are referred to in this text.

Professional negligence in a healthcare context

In a healthcare context, professional negligence is often referred to as medical negligence. Whatever expression is used, the legal principles are the same.

Attempts to define negligence (and therefore professional negligence) concisely have resulted in a number of propositions being put forward over the years, most of which, like the definitions of law itself, are generally deficient in one way or another. However, the definition that most simply explains the common-law approach to civil negligence is as follows:

> The categories of negligence are never closed. The cardinal principle of liability is that the party complained of should owe to the party complaining a duty to take care and that the party complaining should be able to prove that he [sic] has suffered damage as a consequence of a breach of that duty.[2]

In bringing a claim, the plaintiff must establish, according to the civil standard of proof, the legal principles that constitute the allegation being made supporting the plaintiff's claim of negligence against the defendant.

In such an action, the plaintiff must establish, on the balance of probabilities, the following four principles:

1) That the defendant owed the plaintiff a duty of care. It follows, if a duty of care is shown to exist, there must be a standard of care inherent in the duty. Therefore, the standard of care expected of the defendant in the incident being complained about must also be established.
2) That the defendant's conduct on the occasion in question fell below the standard expected. If that is established, then the defendant is in breach of his or her duty of care to the plaintiff.

3) That, as a result of the defendant's breach of the duty of care owed to the plaintiff, the plaintiff suffered damage. This principle is often referred to as the principle of causation. That is, the defendant's breach of the duty of care caused the plaintiff's loss and damage. If the plaintiff suffers no damage, no compensation can be awarded. Equally, if the damage being complained about did not arise as a consequence or direct result of the defendant's negligent act, no compensation can be awarded.
4) That the loss and damage the plaintiff is complaining about is a reasonably foreseeable consequence of the defendant's negligent act — otherwise, once again, the plaintiff cannot be awarded compensation. This principle is often expressed by saying that the loss and damage complained of should not be too remote from the negligent act.

In establishing the above principles, the plaintiff must prove all of them according to the civil standard of proof. If the plaintiff fails to prove one of them, the plaintiff fails completely in the action against the defendant.

It is now necessary to examine carefully each of the principles identified above, with particular reference to nurses and midwives acting in their professional capacity.

Negligence: Principle 1 — that the defendant owed the plaintiff a duty of care

DUTY OF CARE AS A NURSE OR MIDWIFE

It has long been determined by the courts that, as far as your professional activities are concerned, a duty of care is owed to patients, fellow employees and potentially other persons. To understand the application of that principle, one should refer to the historic decision given in 1932 by the English House of Lords (then a superior court of appeal whose decisions bound Australian courts). That decision laid down the now well-established principles concerning the existence and scope of one's duty of care in an action alleging civil negligence.[3]

The case for determination by the House of Lords concerned an action that arose when the plaintiff had consumed a bottle of ginger beer that contained the decomposed remains of a snail and she became ill. She brought an action against the manufacturer alleging, among other issues, that the manufacturer owed her a duty of care in the manufacture of its product. Today, the existence of such a duty would not even be put in issue and the authority for that proposition is the principle laid down in the case under discussion. The significance of the decision can therefore be readily appreciated as a milestone in the development of the law in this area.

In handing down the historic decision, the judges stated that the manufacturer did owe a duty of care to all the potential consumers of its product, who, of course, included the plaintiff. In determining the extent and the existence of a duty of care generally, they stated that each of us owed a duty of care, in law, to our neighbour. In response to the question, 'Who, in law, is my neighbour?', the answer given in the decision of the court was:

> … persons who are so closely and directly affected by my act that I ought reasonably to have had them in my contemplation as being likely to be damaged when I set out to do the acts or omissions which are now being complained of.[4]

Obviously in the course of undertaking work as a nurse or midwife, one's professional actions closely and directly affect patients, fellow employees and potentially other persons so much so that it can reasonably be foreseen that, if a nurse or midwife undertakes a professional task and does it badly, or fails to do a task expected of the nurse or midwife in the course of his or her work, one or all of those categories of people may be injured. Therefore, those people are the 'neighbours in law' of the nurse or midwife and a duty of care clearly exists in relation to them.

A good example of how the scope or extent of one's duty of care can extend beyond the patient or fellow employee to a third party is the decision of the New South Wales Supreme Court in the case known as *BT (as administratrix of the estate of the late AT) v Oei*.[5] In that case, the defendant, Dr Oei, was a general practitioner. AT was his patient. In late 1991, Dr Oei first saw AT and treated him for a flu-like illness. In early 1992, AT was again seen by Dr Oei as his earlier symptoms had not settled. Tests taken at that time revealed a urinary tract infection and hepatitis. Dr Oei did ask AT at that time about his sexual activities and whether he was an intravenous drug user. AT denied any history of drug taking and referred to 'casual sexual exploits' as a possible source of hepatitis B. At that time, Dr Oei gave AT a number of pamphlets about hepatitis B and safe sex practices but, despite the evidence of hepatitis, Dr Oei did not recommend that AT have a HIV test. As a result AT was unaware of his HIV status. AT subsequently formed a sexual relationship with BT. They had unprotected sex on a number of occasions and AT passed the virus to BT who subsequently became ill. BT sued Dr Oei for professional negligence. BT claimed that Dr Oei, who owed a duty of care to AT as his patient, should have suspected a HIV infection and advised AT to have a HIV test when he first presented. BT argued, and the court agreed that, if Dr Oei had done so, AT's HIV status would have been detected early enough for him to have practised safe sex with BT and, as a consequence, BT would not have contracted the HIV infection.

In coming to the conclusion that it did, the court had regard to the obligation imposed on medical practitioners under the *Public Health Act 1991* (NSW). Under that Act, a doctor who reasonably believes a patient may have a HIV infection is required to inform that patient of the danger that he or she poses to others, including sexual partners in particular, and the measures the patient should take to protect others from infection.

It is important to emphasise that the determination of a duty of care embraces 'acts *or omissions* which are now being complained of'. Liability can arise as much by a failure to do a particular act as it can by doing it and doing it badly.

WHAT IS THE POSITION OUTSIDE OF WORK?

At common law, the primary principle that determines whether or not a duty of care is owed to a person or class of persons, and liability arises, is the recognition

of 'reasonable foreseeability of harm' occurring as a result of a person's particular activities.

However, the recommendations arising from the Ipp Report have resulted in legislative changes in some of the states and territories that have placed limitations on categories of activities where it is stated no liability will arise.

The legislation introduced by each of the states and territories following the release of the Ipp Report does not attempt to precisely define 'duty of care' in the context of civil negligence. What the states and territories have done is to enshrine in their respective legislation the general common-law principle of reasonable foreseeability of harm which is relevant to determining whether a duty of care arises in relation to any activity or undertaking. For example, section 5B of the *Civil Liability Act 2002* (NSW) states:

> 1) A person is not negligent in failing to take precautions against a risk of harm unless:
> a) the risk was foreseeable (that is, it is a risk of which the person knew or ought to have known), and
> b) the risk was not insignificant, and
> c) in the circumstances, a reasonable person in the person's position would have taken those precautions.
> 2) In determining whether a reasonable person would have taken precautions against a risk of harm, the court is to consider the following (amongst other relevant things):
> a) the probability that harm would occur if care were not taken,
> b) the likely seriousness of the harm,
> c) the burden of taking precautions to avoid the risk of harm,
> d) the social utility of the activity that creates the risk of harm.

With the exception of the Northern Territory, all of the states as well as the Australian Capital Territory have incorporated a similar statement of general principles in their respective legislation. See *Civil Law (Wrongs) Act 2002* (ACT) ss 42 and 43; *Civil Liability Act 2003* (Qld) s 9; *Civil Liability Act 1936* (SA) s 36; *Civil Liability Act 2002* (Tas) s 11; *Wrongs Act 1958* (Vic) s 48; *Civil Liability Act 2002* (WA) s 5B.

In a majority of the states and territories, the legislative changes identify a category of activities where, it is said, liability will not automatically arise. Such provisions, where applicable, intentionally negate the notion of a duty of care arising in relation to the nominated categories of activity.

The first category where liability is conditional are those defendants engaged in activities that may be considered socially valuable. These include:

- public authorities, particularly those which provide or manage services for the general benefit of the community, or exercise regulatory functions. See *Civil Law (Wrongs) Act 2002* (ACT) ss 109–113; *Civil Liability Act 2002* (NSW) ss 41–45; *Civil Liability Act 2003* (Qld) ss 34–37; *Civil Liability Act 1936* (SA) s 42; *Civil Liability Act 2002* (Tas) ss 38, 40, 42 and 47; *Wrongs Act 1958* (Vic) ss 79, 83 and 84; *Civil Liability Act 2002* (WA) ss 50–52 regarding

road authorities specifically. No similar provisions appear in the relevant legislation of the Northern Territory.

- 'good Samaritans' who provide assistance in emergencies. See *Civil Law (Wrongs) Act 2002* (ACT) s 5; *Civil Liability Act 2002* (NSW) ss 56–57; *Personal Injuries (Liabilities and Damages) Act 2003* (NT) s 8; *Civil Liability Act 2003* (Qld) ss 26–27; *Civil Liability Act 1936* (SA) s 74; *Wrongs Act 1958* (Vic) s 31B; *Civil Liability Act 2002* (WA) ss 5AB and 5AD. No similar provision is made in the relevant Tasmanian legislation. The obligation imposed on healthcare professionals including nurses and midwives as 'good Samaritans' is discussed in more detail further in this chapter.
- volunteers involved in carrying out work for a community organisation. See *Civil Law (Wrongs) Act 2002* (ACT) ss 6–11; *Civil Liability Act 2002* (NSW) ss 59–66; *Personal Injuries (Liabilities and Damages) Act 2003* (NT) s 7; *Civil Liability Act 2003* (Qld) ss 39–44; *Civil Liability Act 2002* (Tas) ss 44–49; *Wrongs Act 1958* (Vic) ss 34–41. No similar provisions appear in the relevant legislation of South Australia and Western Australia.

The second category where liability may not arise is where the plaintiff is engaged in particular activities where it is considered the plaintiff should bear the risks associated with that activity. The intention of such provisions is to preclude or limit the ability of a person bringing a claim for compensation alleging negligence where the person is engaged in inherently and/or obviously risky behaviours or activities, which include:

- activities that involve inherent and/or obvious risks;
- certain recreational activities referred to as a 'dangerous recreational activity';
- consumption of alcohol, or other drugs;
- criminal activity, including where the defendant acts in self-defence.

As an example in relation to the above, section 5K of the *Civil Liability Act 2002* (NSW) defines 'dangerous recreational activity' as recreational activity that involves a significant risk of physical harm and 'recreational activity' includes:

> a) any sport (whether or not the sport is an organised activity), and
> b) any pursuit or activity engaged in for enjoyment, relaxation or leisure, and
> c) any pursuit or activity engaged in at a place (such as a beach, park or other public open space) where people ordinarily engage in sport or in any pursuit or activity for enjoyment, relaxation or leisure.

Taken together, the effect of all of the above provisions is that, outside one's professional activities as a nurse or midwife, whether a duty of care is owed would depend, in the first instance, on considerations relating to the facts and circumstances of the activity giving rise to the allegation of negligence and whether that activity meets the test to determine whether a duty of care arises. To do so, it is necessary to consider whether the facts and circumstances of the activity complained

of fell into one of the above categories where the relevant civil liability legislation now provides that liability generally does not arise.

DETERMINING THE STANDARD OF CARE FOR HEALTHCARE PROFESSIONALS GENERALLY

Numerous court cases involve allegations of negligence involving healthcare professionals, particularly medical practitioners. Given the major role that medical practitioners play in diagnosing, delivering and determining the healthcare to be given to a patient, it is not surprising that of the professional negligence cases dealt with by the courts, the great majority of them involve allegations of negligence against members of the medical profession. As a consequence, the case law developed by the courts, particularly the High Court, in determining the standard of care expected in the delivery of health services is made up of cases concerning the actions of a medical practitioner in specific clinical circumstances. Notwithstanding the focus on medical practitioners, the legal principles that have emerged from these cases are relevant to all healthcare professionals, including nurses and midwives, involved in delivering healthcare and/or providing advice and information about proposed healthcare.

The principal cases determined by the courts involving doctors and the standard of care expected have all centred around the standard of care expected of them in two aspects of their work — the standard of care expected in the actual performance of their work and the standard of care expected in giving information and advice to patients about material risks inherent in the treatment proposed. On that issue, the Ipp Report noted:

> Issues about the standard of care in medical negligence cases may arise in relation to treatment (which includes diagnosis, the prescribing of medications and the carrying out of procedures) and to the giving of information about treatment. The Panel considers that the provision of treatment on the one hand, and the provision of information on the other, is a very important one, and that the law should deal with these activities in different ways. The standard of care therefore has to be discussed separately in regard to each.[6]

The outcome is that, in the provision of healthcare, the standard of care expected in 'treatment' cases differs from the standard of care expected in 'information' cases (the giving of information and/or advice, the disclosure of risk and the provision of warnings). That approach does not only apply to medical practitioners but also to other healthcare professionals, including nurses and midwives.

STANDARD OF CARE IN TREATMENT CASES

The standard of care expected of medical practitioners, nurses and midwives in the actual performance of their work (treatment cases), is the same as for other healthcare professionals (and professionals generally). That obligation is provided for in case law as determined by the courts together with the civil liability legislation of the states and territories referred to earlier; that is, that in the performance of his or her work, a healthcare practitioner should exercise a level of skill and care that,

at the time, is 'widely accepted' by 'peer professional opinion' to be 'competent professional practice'. In the Australian Capital Territory, section 42 of the *Civil Law (Wrongs) Act 2002* applies the 'reasonable person in the defendant's position' test which is in many respects simply a reaffirmation of the common-law principle of the 'ordinary reasonable person'. In the Northern Territory, there is no legislative provision in place and so the common-law principles as supported by case law would apply.

In many respects, the test of 'peer professional opinion' in relation to medical practitioners in particular had earlier been expressed in cases determined by the courts both here and in the United Kingdom. The principle that emerged from such cases was known as the *Bolam* test. The case originated from the United Kingdom decision of *Bolam v Friern Hospital Management Committee* (1957).[7] The relevant facts are set out below.

Mr Bolam was admitted to hospital as a voluntary patient to undergo electro-convulsive therapy (ECT) for depression. In accordance with his usual practice at the time, the treating doctor administered the ECT unmodified; that is, no relaxant drug was given before the treatment and no manual restraint was applied other than holding Mr Bolam's chin and nurses being present on either side of the couch in case he fell off. During the treatment, Mr Bolam sustained bilateral fractures of the pelvis caused by the head of the femur being driven through the acetabulum. Mr Bolam sued the hospital, alleging that the doctor was negligent on three grounds:

1) failing to administer any relaxant drug prior to the ECT;

2) failing to provide some adequate form of manual control or restraint;

3) failing to warn Mr Bolam of the risks involved in the treatment.

In addressing the jury in the case, the judge described the standard expected of the ordinary reasonable doctor as follows:

> … the test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.[8]

The doctors treating Mr Bolam stated that it was not their practice to warn patients of the risks of the treatment unless asked; if asked they normally said there was a slight risk. Evidence was given by expert medical witnesses who stated that while relaxants and restraints were used by some doctors, other doctors did not use them. Mr Bolam was unsuccessful in his action.

The outcome in Mr Bolam's case was that the question of whether or not a patient had been properly treated and informed as to the risks inherent in the proposed treatment depended entirely on what the medical profession thought was reasonable in all the circumstances. The added burden was then imposed on the patient that, having been informed to the extent that the medical profession as a body of opinion thought was reasonable, he was then required to show that, had he been warned, he would not have had the treatment.

The central tenet of the *Bolam* test or principle was that the standard of care expected of medical practitioners was determined by reference to professional practice based on 'a responsible body of medical men skilled in that particular act' as the following statement from the judgment in that case confirmed that:

> … a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art … merely because there is a body of opinion that would take a contrary view.[9]

The test established in *Bolam* was later affirmed in a 1985 case in the United Kingdom in the following terms:

> The *Bolam* principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care: but the standard of care is another matter of medical judgment.[10]

In Australia, the High Court modified the *Bolam* test in that they confirmed it as the principle to be applied in determining the standard of care for medical practitioners (as well as other healthcare professionals) in relation to 'treatment' cases but rejected it in relation to 'information' cases and the test to be applied. That was the outcome of the High Court in the decision of *Rogers v Whitaker*.[11] The relevant facts are set out below.

In 1946, when Mrs Whitaker was only 9 years old, her right eye had suffered a penetrating injury from a piece of wood in an accident. As a result she became almost totally blind in that eye. However, she retained normal vision in her left eye. Despite this handicap Mrs Whitaker was able to lead a normal life. She completed her schooling and after leaving school worked in a variety of occupations including shop assistant, enrolled nurse's aide and health studio manager. In 1959 she married and she and her husband had four children. In between having children she was able to work in various occupations.

Mrs Whitaker ceased employment in 1980 to look after her son Joshua who had been injured in a car accident. By 1983, she had formed the intention of going back to work, possibly as a nurse's aide, and with employment in mind she set out to obtain an eye 'check up'. She was referred by her general practitioner to Dr Cohen, an ophthalmologist, who she saw on 23 June 1983. Dr Cohen prescribed reading glasses and referred Mrs Whitaker to Dr Rogers for possible surgery on her right eye; in the words of his referral 'if you think she would benefit, even cosmetically'. Dr Cohen described Dr Rogers to Mrs Whitaker as a 'cornea graft expert'. Family circumstances prevented Mrs Whitaker from following up the referral until the following year when she saw Dr Rogers for the first time, with her husband, on 22 May 1984.

Following his examination of Mrs Whitaker, Dr Rogers told her that he could operate on her right eye to remove the scar tissue. This would improve the appearance of the eye, but at the same time would probably restore significant sight to

that eye. He also discussed the possibility of further procedures including a cornea graft which could further improve her sight, and an operation to correct a slight squint in that eye. He also explained that the first operation would assist in managing her early glaucoma.

At the second consultation on 15 June 1984 Mrs Whitaker agreed to submit to surgery on her right eye and the procedure was carried out on 1 August of that year. Subsequently complications developed in the right eye and then in the left eye, although that eye had not been interfered with during the operation. This was the result of a rare condition known as 'sympathetic ophthalmia'. This is a serious complication of eye surgery involving inflammation in the treated eye and sympathetic inflammation in the untreated eye. It carries with it a serious risk of blindness. Ultimately Mrs Whitaker lost the sight of her left eye, becoming virtually blind by the beginning of 1986.

Mrs Whitaker brought an action against Dr Rogers for professional negligence. She alleged that Dr Rogers was negligent on the following six grounds:

1) failing to carry out certain tests before operating;
2) recommending and performing an ill-advised operation;
3) failing to warn Mrs Whitaker of the risk of sympathetic ophthalmia;
4) failing to follow up missed appointments by Mrs Whitaker after surgery;
5) failing to advise Mrs Whitaker adequately as to the use of prescribed medication;
6) failing to enucleate the right eye following the development of symptoms of sympathetic ophthalmia in the left eye.

The judge rejected all of the allegations of negligence with the exception of ground 3 above. He upheld the allegation of failure to warn and in doing so relied on a number of issues which were established by the evidence given, namely:

- that Mrs Whitaker was, to Dr Rogers' knowledge, keenly interested in the outcome of the suggested procedures including any complications so far as they affected her eyes — although she did not think of damage to the left eye as a result of the operation on the right eye apart from that which might be caused by unintended or accidental interference with her left eye;
- that Mrs Whitaker incessantly questioned Dr Rogers as to, amongst other things, possible complications, to the point of irritating him;
- that Dr Rogers was aware of the risk of sympathetic ophthalmia, although remote, and in 1984 thought that the risk, although still remote, might have been increased by earlier injury;
- that Dr Rogers considered sympathetic ophthalmia the worst possible ophthalmic result;
- that the absence of any warning as to the risk of sympathetic ophthalmia was not for any therapeutic reason, but rather that, in the circumstances, the condition would not come to mind to mention it.

In summary, the judge found that Dr Rogers had been negligent in failing to warn the respondent of the risk of sympathetic ophthalmia and that if such a warning had been given Mrs Whitaker would not have undergone surgery in her right eye. Mrs Whitaker was awarded compensation and Dr Rogers appealed to the New South Wales Court of Appeal.

The New South Wales Court of Appeal dismissed Dr Rogers' appeal and he appealed to the High Court of Australia.

The High Court unanimously dismissed Dr Rogers' appeal and in doing so adopted the *Bolam* principle as the general standard applicable to a person with special skill and competence as follows:

> In Australia, it has been accepted that the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill.[12]

The High Court decision in *Rogers v Whitaker* continues to be the relevant common law authority in determining the standard of care expected of medical practitioners (and other healthcare professionals) in treatment cases. That is, the standard expected will be determined by reference to what would be the level of skill and expertise accepted by a responsible body of peer opinion as being competent professional practice, at the time, having regard to the facts and circumstances then prevailing.

Some time after the decision in *Rogers v Whitaker* and following the recommendations of the Ipp Report, the states and territories introduced the civil liability legislation mentioned earlier. As a consequence, the standard of care expected of healthcare professionals in treatment cases, as enunciated in *Rogers v Whitaker* (and other cases), is now influenced by the standard of care provisions applying to professionals in that legislation.

LEGISLATIVE PROVISIONS RELEVANT TO DETERMINING THE STANDARD OF CARE

With the exception of the Northern Territory, each state and territory has legislated in relation to the expected standard of care in civil negligence matters. Further, most have made specific provisions for the standard of care for 'professionals' or, in the case of Western Australia, specifically for 'health professionals'. The Australian Capital Territory legislation refers simply to the standard of care expected of a 'reasonable person in the defendant's position'. Because of the absence of uniformity of approach on this issue, it is important for nurses and midwives to be aware of those differences depending on the particular state or territory in which they are practising. The relevant legislative provisions of each state and territory are set out below.

Australian Capital Territory

Section 42 of the *Civil Law (Wrongs) Act 2002* provides for the standard of care for professionals as follows:

> For deciding whether a person (the ***defendant***) was negligent, the standard of care required of the defendant is that of a reasonable person in the defendant's position who was in possession of all the information that the defendant either had, or ought reasonably to have had, at the time of the incident out of which the harm arose.

New South Wales

Section 5O of the *Civil Liability Act 2002* provides as follows:

1) A person practising a profession (***a professional***) does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.
2) However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.
3) The fact that there are differing peer professional opinions widely accepted in Australia concerning a matter does not prevent any one or more (or all) of those opinions being relied on for the purposes of this section.
4) Peer professional opinion does not have to be universally accepted to be considered widely accepted.

Queensland

Section 22 of the *Civil Liability Act 2003* provides as follows:

1) A professional does not breach a duty arising from the provision of a professional service if it is established that the professional acted in a way that (at the time the service was provided) was widely accepted by peer professional opinion by a significant number of respected practitioners in the field as competent professional practice.
2) However, peer professional opinion can not be relied on for the purpose of this section if the court considers that the opinion is irrational or contrary to a written law.
3) The fact that there are differing peer professional opinions accepted by a significant number of respected practitioners in the field concerning a matter does not prevent any 1 or more (or all) of the opinions being relied on for the purposes of this section.
4) Peer professional opinion does not have to be universally accepted to be considered widely accepted.
5) This section does not apply to liability arising in connection with the giving of (or the failure to give) a warning, advice or other information, in relation to the risk of harm to a person, that is associated with the provision by a professional of a professional service.

South Australia

Section 41 of the *Civil Liability Act 1936* provides as follows:

1) A person who provides a professional service incurs no liability in negligence arising from the service if it is established that the provider acted in a manner that (at the time the service was provided) was widely accepted in Australia by members of the same profession as competent professional practice.

2) However, professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.
3) The fact that there are differing professional opinions widely accepted in Australia by members of the same profession does not prevent any one or more (or all) of those opinions being relied on for the purposes of this section.
4) Professional opinion does not have to be universally accepted to be considered widely accepted.
5) This section does not apply to liability arising in connection with the giving of (or the failure to give) a warning, advice or other information in respect of a risk of death of or [sic] injury associated with the provision of a health care service.

Tasmania

Section 22 of the *Civil Liability Act 2002* provides as follows:

1) A person practising a profession ('a professional') does not breach a duty arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.
2) Peer professional opinion cannot be relied on for the purpose of this section if the court considers that the opinion is irrational.
3) The fact that there are differing professional opinions widely accepted in Australia concerning a matter does not prevent any one or more (or all) of those opinions being relied on for the purpose of subsection (1).
4) Peer professional opinion does not have to be universally accepted to be considered widely accepted.
5) This section does not apply to liability arising in connection with the giving of (or the failure to give) a warning, advice or other information in relation to the risk of harm associated with the provision by a professional of a professional service to a person.

Victoria

Sections 58 and 59 of the *Wrongs Act 1958* provide as follows:

Section 58:

In a case involving an allegation of negligence against a person (the defendant) who holds himself or herself out as possessing a particular skill, the standard to be applied by a court in determining whether the defendant acted with due care is, subject to this Division, to be determined by reference to —

a) what could reasonably be expected of a person possessing that skill; and
b) the relevant circumstances as at the date of the alleged negligence and not a later date.

Section 59:

1) A professional is not negligent in providing a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by a significant number of respected practitioners in the field (peer professional opinion) as competent professional practice in the circumstances.
2) However, peer professional opinion cannot be relied on for the purposes of this section if the court determines that the opinion is unreasonable.
3) The fact that there are differing professional opinions widely accepted in Australia by a significant number of respected practitioners in the field concerning a matter does not prevent any one or more (or all) of those opinions being relied on for the purposes of this section.
4) Peer professional opinion does not have to be universally accepted to be widely accepted.
5) If, under this section, a court determines peer professional opinion to be unreasonable, it must specify in writing the reasons for that determination.
6) Subsection (5) does not apply if a jury determines the matter.

Western Australia

Western Australia is the only state to have a specific standard of care for healthcare professionals. Section 5PB of the *Civil Liability Act 2002* provides as follows:

1) An act or omission of a health professional is not a negligent act or omission if it is in accordance with a practice that, at the time of the act or omission, is widely accepted by the health professional's peers as competent professional practice.
2) Subsection (1) does not apply to an act or omission of a health professional in relation to informing a person of a risk of injury or death associated with —
   a) the treatment proposed for a patient or a foetus being carried by a pregnant patient; or
   b) a procedure proposed to be conducted for the purpose of diagnosing a condition of a patient or a foetus carried by a pregnant patient.
3) Subsection (1) applies even if another practice that is widely accepted by the health professional's peers as competent professional practice differs from or conflicts with the practice in accordance with which the health professional acted or omitted to do something.
4) Nothing in subsection (1) prevents a health professional from being liable for negligence if the practice in accordance with which the health professional acted or omitted to do something is, in the circumstances of the particular case, so unreasonable that no reasonable health professional in the health professional's position could have acted or omitted to do something in accordance with the practice.
5) A practice does not have to be universally accepted as competent professional practice to be considered widely accepted as competent professional practice.

6) In determining liability for damages for harm caused by the fault of a health professional, the plaintiff always bears the onus of proving, on the balance of probabilities, that the applicable standard of care (whether under this section or any other law) was breached by the defendant.

It is important to note that section 42 of the Australian Capital Territory legislation set out above does not refer to persons practising as 'professionals' or to persons holding 'himself or herself out as possessing a particular skill'. Consequently it is of wider application and would apply to any defendant in a civil negligence action.

Northern Territory

In the absence of any specific legislative provision, the determination of the standard of care where negligence is alleged would be determined by reference to the tests enunciated in *Rogers v Whitaker* for both 'treatment' and 'information' cases.

THE DETERMINATION OF THE STANDARD OF CARE IN TREATMENT CASES FOLLOWING THE INTRODUCTION OF THE CIVIL LIABILITY LEGISLATION IN THE STATES AND TERRITORIES

Following the introduction of the civil liability legislation in the respective states and territories, the approach taken by the courts in determining whether a medical practitioner (or any other health professional) has been negligent in treatment cases, has been to apply the principle established in *Rogers v Whitaker* qualified by the relevant civil liability provision of the particular state or territory relating to the determination of the standard of care. For example, in New South Wales, in adopting such an approach, section 5O of the *Civil Liability Act 2002* would arise for consideration. Where that has been done it has been held to operate as a defence. This approach was adopted in the New South Wales Supreme Court decision of *Halverson v Dobler; Halverson (by his tutor) v Dobler*.[13] In that case, Kurt Halverson sued his general practitioner, Dr Dobler, for negligence for failing to properly diagnose his cardiac problems and refer him to a specialist before he suffered a cardiac arrest and sustained catastrophic injuries due to hypoxic brain damage. In determining the matter and after hearing expert peer evidence and finding Dr Dobler negligent McClellan J stated:

> … the standard of care is still the standard that was endorsed in *Rogers v Whitaker*, but if a defendant is found to be negligent under this standard he or she can avoid liability if they can establish that they acted in a manner which was widely accepted in Australia by peer professional opinion as competent professional practice.[14]

And further:

> In my view the section is intended to operate as a defence. The section is expressed so that 'a person practising a profession … *does not incur a liability in negligence*' if a certain state of affairs can be 'established'. The italicised words go to the issue of liability, not to the issue of negligence.[15]

The approach enunciated in *Halverson v Dobler* above was confirmed on appeal by the New South Wales Court of Appeal. It would be expected that a similar approach would be adopted in the other states and territories with civil liability legislation incorporating standard of care provisions equivalent to section 5O of the *Civil Liability Act 2002* (NSW).

THE STANDARD OF CARE IN INFORMATION CASES

In confirming the test to be applied in determining the standard of care expected of healthcare professionals in giving information, including advice as to the risks and the likely outcome of the proposed treatment, the High Court stated in *Rogers v Whitaker*:

> Further, and more importantly, particularly in the field of non-disclosure of risk and the provision of advice and information, the *Bolam* principle has been discarded and, instead, the courts have adopted the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to 'the paramount consideration that a person is entitled to make his own decisions about his life'.[16]

The High Court further commented:

> … except in cases of emergency or necessity, all medical treatment is preceded by the patient's choice to undergo it. In legal terms, the patient's consent to the treatment may be valid once he or she is informed in broad terms of the nature of the procedure which is intended. But the choice is, in reality, meaningless unless it is made on the basis of relevant information and advice. Because the choice to be made calls for a decision by the patient on information known to the medical practitioner but not to the patient, it would be illogical to hold that the amount of information to be provided by the medical practitioner can be determined from the perspective of the practitioner alone or, for that matter, of the medical profession.[17]

It is clear, in arriving at their decision in *Rogers v Whitaker*, that the High Court shifted the determination of the adequacy or otherwise of advice and information about proposed treatment to be given to a patient from the 'responsible body of medical opinion' to the courts, having regard at all times to the necessary information and advice to be given to the patient in order to obtain his or her consent.

The decision in *Rogers v Whitaker* was a very important one in the field of medico–legal litigation concerning the standard of care expected in 'information' cases. It shifted the emphasis in relation to the adequacy of information and advice to be given to a patient, from the doctors' belief as to what was reasonable, to what the patient in his or her particular circumstances would consider reasonable.

Following its decision in *Rogers v Whitaker*, the High Court reaffirmed its view on this issue. The decision that did so emphatically was that in *Chappel v Hart*.[18] The relevant facts and findings of the court are set out below.

Dr Chappel was an ear, nose and throat specialist. In June 1983, Mrs Hart underwent surgery at the hands of Dr Chappel for the removal of a pharyngeal pouch in her oesophagus. During that procedure, her oesophagus was perforated and there ensued an infection known as mediastinitis. This was caused by bacteria present in the oesophagus escaping through the perforation into the mediastinum, which is part of the chest cavity. Mrs Hart recovered from the perforated oesophagus and mediastinitis, but the infection damaged the laryngeal nerve and led to a paralysis of the right vocal cord. This affected the performance by Mrs Hart of her duties in a senior position in the New South Wales Department of Education. In 1985, she was retired from that position on medical grounds.

In June 1983, the surgical procedure was 'elective' for Mrs Hart, although at a later stage the position would have been reached where it could no longer sensibly be deferred. The evidence did not indicate with any precision when Mrs Hart's condition would have reached that stage. Mrs Hart sued Dr Chappel for breach of contract and negligence. Mrs Hart alleged that she had consulted Dr Chappel for advice concerning medical problems relating to her throat and that, after the receipt of his advice to undergo a surgical procedure, engaged Dr Chappel to carry out that procedure.

Mrs Hart stated that her agreement with Dr Chappel contained an implied term that he would warn her of all risks associated with the procedure, that he had failed to warn her of those risks and he caused or allowed her injuries to be caused. In particular, she alleged that Dr Chappel, before obtaining her consent to carry out the procedure, had failed to warn her of the risks of sustaining the injuries which she in fact sustained. She stated that if he had so warned her she would not have had the operation by Dr Chappel at that time but would have waited and sought alternative specialist advice. Mrs Hart further alleged that, in consequence of this negligence and breach of contract, she had sustained a perforated oesophagus and consequent paralysis of the right vocal cord.

Applying the principles laid down in *Rogers v Whitaker*, the Supreme Court of New South Wales found in Mrs Hart's favour. Dr Chappel appealed to the New South Wales Court of Appeal. So too did Mrs Hart, but that action is not relevant for consideration here.

The Court of Appeal dismissed Dr Chappel's appeal (and Mrs Hart's). He appealed to the High Court arguing, in essence, that Mrs Hart's damage and loss was not caused by his failure to warn her of the material risk of the damage that did occur. Mrs Hart had said that if she had known of the possibility of the damage that occurred she would not have agreed to allow Dr Chappel to operate when he did and she would have had a more experienced specialist surgeon perform the procedure at a later time.

Dr Chappel argued that the damage that had occurred to Mrs Hart was 'a random event involving no negligent procedure' and there was no evidence that deferring the operation for some future time would have diminished the risk of the same kind of damage occurring.

The High Court appeal was heard by a bench of five judges. By a majority of three to two, the court dismissed Dr Chappel's appeal. In the dismissal, the High Court expressly reaffirmed the view they had expressed in *Rogers v Whitaker*, that is:

> … a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment …[19]

And that:

> … a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's condition, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.[20]

One of the High Court judges who dismissed Dr Chappel's appeal was Justice Michael Kirby. In restating the decision of the High Court in *Rogers v Whitaker* in the above passage, Kirby J said:

> These standards have fairly been described as onerous. They are. But they are the law. They are established for good reason. When not complied with (as was held to be so in this case) it should occasion no surprise that legal consequences follow. This was an unusual case where the patient was found to have made very clear her concerns. The practicalities are that, had those concerns been met as the law required, the overwhelming likelihood is that the patient would not, in fact, have been injured. So much was eventually conceded. In such circumstances, commonsense reinforces the attribution of legal liability. It is true to say that the inherent risks of injury from rare and random causes arise in every surgical procedure. A patient, duly warned about such risks, must accept them and their consequences. Mrs Hart was ready to accept any general risks of the operation of which she was warned. However, she declined to bear the risks about which she questioned the surgeon and received no adequate response. When those risks so quickly eventuated, commonsense suggests that something more than a mere coincidence or irrelevant cause has intervened. This impression is reinforced once it is accepted that Mrs Hart, if warned, would not have undergone the operation when she did.[21]

The principle established in *Rogers v Whitaker* and *Chappel v Hart* was reaffirmed by the High Court in *Rosenberg v Percival*.[22] Those decisions make it clear that the standard of care healthcare professionals owe to their patients includes an obligation not only to treat them competently according to professional standards but also to inform, advise and warn them about risks associated with the proposed treatment, to answer their questions candidly and to respect their rights (including, where they so choose, to postpone medical procedures and go elsewhere for treatment).

In addition to the case law, the civil liability legislation in some of the states and territories has made specific provision for a medical practitioner to warn patients of 'risks in treatment' whereas in other states there is no duty to disclose 'obvious risks' except in some circumstances as provided in the legislation. Queensland and Tasmania provide for what is described as a proactive and reactive duty of a medical practitioner to warn of risks. For example, section 21 of the *Civil Liability Act 2003* (Qld) states:

1) A doctor does not breach a duty owed to a patient to warn of risk, before the patient undergoes any medical form of treatment (or at the time of being given medical advice) that will involve a risk of personal injury to the patient, unless the doctor at that time fails to give or arrange to be given to the patient the following information about the risk —
   a) information that a reasonable person in the patient's position would, in the circumstances, require to enable the person to make a reasonably informed decision about whether to undergo the treatment or follow the advice;
   b) information that the doctor knows or ought reasonably to know the patient wants to be given before making the decision about whether to undergo the treatment or follow the advice.

…

Section 21 of the Tasmanian *Civil Liability Act 2002* is in similar terms except that the above obligations are exempted in emergency circumstances where it is necessary to save life and/or where the patient is unable to be consulted or advised because of prevailing circumstances.

In Victoria the obligation to warn of risk is not confined to doctors and, in our view, simply restates the common law position. Section 50 of the *Wrongs Act 1958* states:

> A person (the defendant) who owes a duty of care to another person (the plaintiff) to give a warning or other information in respect of a risk or other matter, satisfies that duty of care if the defendant takes reasonable care in giving that warning or other information.

In New South Wales, Queensland, South Australia, Tasmania, Victoria and Western Australia there is no duty to warn of 'obvious risks' *but* in most of the states there are limits to such a provision relevant to healthcare professionals. For example, section 5H of the *Civil Liability Act 2002* (NSW) states:

1) A person (***the defendant***) does not owe a duty of care to another person (***the plaintiff***) to warn of an obvious risk to the plaintiff.
2) This section does not apply if:
   a) the plaintiff has requested advice or information about the risk from the defendant, or
   b) the defendant is required by a written law to warn the plaintiff of the risk, or
   c) the defendant is a professional and the risk is a risk of the death of or personal injury to the plaintiff from the provision of a professional service by the defendant.
3) Subsection (2) does not give rise to a presumption of a duty to warn of a risk in the circumstances referred to in that subsection.

As a proper reading of that section confirms, healthcare professionals would almost invariably not be exempted from a duty to warn of an 'obvious risk' as they are generally in the business of responding to a request from a patient or client for

advice or information about proposed treatment, and the person asking for advice or information faces a risk of death or personal injury arising from the services provided by a healthcare professional.

Similar provisions apply in the following states: *Civil Liability Act 2003* (Qld) ss 13–15; *Civil Liability Act 1936* (SA) ss 36–38; *Civil Liability Act 2002* (Tas) ss 15–17; *Wrongs Act 1958* (Vic) ss 53, 54 and 56; *Civil Liability Act 2002* (WA) ss 5M–5O.

There are no such provisions in the Australian Capital Territory or the Northern Territory.

THE STANDARD OF CARE EXPECTED OF NURSES AND MIDWIVES ACTING IN A PROFESSIONAL CAPACITY

The approach to be taken in establishing the standard of care for nurses and midwives is the same as for other healthcare professionals.

The long-established common-law principle reaffirmed in *Rogers v Whitaker* is that, in the course of carrying out his or her professional activities, a nurse or midwife is required to exercise the skill and care that, objectively, would be accepted by one's professional peers as competent professional practice given the facts and circumstances under consideration. The same approach would be taken when considering the actions of a registered nurse when compared with an enrolled nurse in the same clinical situation. The level of skill and care expected of an enrolled nurse in a particular clinical situation would generally be of a different standard than that expected of a registered nurse, because the expected skills and knowledge of an enrolled nurse is less than that of a registered nurse. As always, it would depend on the facts and circumstances of the particular situation and considered within an objective context.

EXPERT EVIDENCE FROM PROFESSIONAL PEERS

Notwithstanding the differences in the respective state and territory legislation, there is what can be described in our opinion as a common approach to the determination of the requisite professional standard in any particular situation. That is, that the approach to determining the requisite standard of care requires evidence of a professional standard that is 'widely accepted' by 'peer professional opinion' as being 'competent professional practice'. The majority of the states (New South Wales, South Australia, Tasmania and Victoria) provide that the professional standard be widely accepted 'in Australia' whereas Queensland and Western Australia provide no such limitation which would allow evidence of a professional standard to be obtained from overseas medical experts. Remember also that the Northern Territory makes no legislative provision for the determination of the requisite standard of care in a professional situation, therefore, the common-law principle established in *Rogers v Whitaker* would apply and evidence would be elicited from one's professional peers in order to determine what would have been expected of the 'professionally competent' nurse or midwife in a specific clinical situation. Likewise is the case in the Australian Capital Territory.

Evidence elicited from one's professional peers is generally the first step in determining the standard of care expected in a specific clinical situation. Therefore, if an incident occurred in an operating theatre, where the actions of a nurse were alleged

to have been negligent, evidence would be called from a nurse with considerable experience in operating theatre work and who would be regarded as an expert in that area by her or his peers. That nurse would be asked to give an opinion, on the basis of the known facts, as to what was considered to be widely accepted competent professional practice in such circumstances; that is, what would have been the professional standard expected of a nurse in the particular clinical situation under scrutiny. It is quite possible, of course, that his or her evidence may be rejected or disputed by other nursing experts in the field called in the matter. The ultimate decision as to whether expert evidence is accepted or rejected will be a matter for the judge to determine (or the jury if they are present). The critical point to remember is that it is the profession itself, through the development of skills and the application of professional standards, that will determine what is or is not competent professional practice in any given clinical situation where professional competence is called into question.

The approach is clearly parallelled in other areas of professional activity concerning healthcare professionals. For example, if it were necessary to establish what was competent professional practice in the area of midwifery, expert evidence would be elicited from a midwife considered an expert in the field.

PROFESSIONAL PRACTICE STANDARDS

Nurses and midwives, like many other professional groups within the health industry, have addressed the need for the development of professional standards covering a wide range of their professional activities and responsibilities. The development of such standards is to be applauded and encouraged, as long as they are subject to regular professional peer review and assessment and are generally recognised by the profession as appropriate for the professional activity to which they refer. Like the departmental and employer policy and procedural directives, professional standards documents would, where relevant, clearly provide objective evidence of an expected and competent standard of professional conduct in a given clinical situation.

The courts in Australia and overseas have on occasions seen fit to specifically refer to documented practice and procedure standards as evidence to assist them in determining the standard of care expected of a nurse or midwife in a given situation. A very good example of where the court relied on a professional standards document was in the case of *Langley v Glandore Pty Ltd* — a decision of the Court of Appeal of the Supreme Court of Queensland.[23] The full details of that matter are set out later in this chapter.

That matter involved, amongst other things, the standard expected of nursing staff in operating theatres in relation to the counting of sponges. In commenting on that issue, the court said:

> The relevant established standard for counting of sponges, swabs, instruments and needles is called the 'ACORN' standard and it supports the description of the duties that has been outlined. Importantly, there was no dissent at the trial concerning its applicability.[24]

Nurses who work in operating theatres would know that 'ACORN' refers to the standards adopted by the Australian Council of Operating Room Nurses (ACORN).

As well, a recent Canadian case used the standing orders of an emergency room as the standard against which medical and nursing practice should be measured.[25] In another Canadian case, an entire section of the procedure manual was reproduced in the judgment as it was considered crucial to determining the question of whether or not the practice under review had fallen below the standard of care which could reasonably have been expected.[26]

Closer to home, the Supreme Court of South Australia has made specific reference to professional standards in dealing with an appeal against a finding of a disciplinary tribunal of the Nurses Board of South Australia in the following terms:

> It may be seen that the Board in reaching its decision that the Appellant had been guilty of unprofessional conduct, had regard to the various standards of nursing practice which had been laid down by its own guidelines, the policy of the nursing home, regulations, the International Council of Nursing's Code of Ethics and what it describes as the ANRAC competencies. It may be accepted that those standards are well recognised and accepted in the nursing profession.[27]

STATUTORY OBLIGATIONS

There are often clear legislative obligations on nurses, midwives and other healthcare professionals to undertake specific actions. For example, the *Poisons Act* and *Regulations* of the states and territories generally provide that a registered nurse or midwife is required to check a dangerous drug (generally referred to as a Schedule 8 drug) with another nurse or midwife before administering it. A failure to do so, without reasonable cause and which results in an incorrect drug being administered and the patient suffering harm as a result, would be deemed to be a breach of the nurse or midwife's obligations under the *Poisons Act* and *Regulations*. This would be in addition to a breach of his or her general duty of care to the patient by failing to observe proper professional standards of care and safety in the administration of a dangerous drug.

Another example of where a breach of a statutory obligation by a medical practitioner was relied upon to support an allegation of professional negligence was the case of *BT v Oei*, referred to earlier in this chapter. One of the specific failures cited by the plaintiff against Dr Oei was that he was in breach of the *Public Health Act 1991* (NSW) and *Public Health (General) Regulation 2002* (NSW). On that point the judge agreed, stating relevantly as follows:

> [92] The Public Health Act 1991 s.12(1) requires a medical practitioner who believes on reasonable grounds that his or her partner is suffering from a sexually transmissible medical condition to provide the patient with such information as required by the Regulations of the Act.
>
> Regulation 4 of the Public Health Act sets out the categories of information to be supplied:
>
> a) the means of minimising the risk of infecting other people with the condition;
>
> b) the public health implications of the condition;

c) the responsibilities under s.11 of the Act including any precautions considered reasonable;
d) responsibilities under s.13 of the Act;
e) diagnosis and treatment;
f) treatment options.[28]

[93] Section 13 of the Public Health Act makes it an offence for a person who knows that he or she suffers from a sexually transmissible medical condition to have sexual intercourse with another person unless, before the intercourse takes place, the other person has been informed of the risk of contracting a sexually transmissible medical condition and has voluntarily agreed to accept that risk.

[94] The scheme of the Public Health Act thus requires a medical practitioner who reasonably believes his or her patient to have HIV to inform the patient of the public health implications of the condition and the means of protecting others. The practitioner must inform the patient of the patient's statutory responsibility to warn prospective sexual partners of his or her condition.[29]

In finding Dr Oei negligent, the judge agreed that Dr Oei had, amongst other matters, failed in the circumstances to discharge his statutory obligation to properly advise his patient, AT, of the need to be HIV tested and as a result and at the relevant time, AT had unprotected sex with BT who contracted HIV.

DEPARTMENTAL GUIDELINES AND/OR EMPLOYER POLICY AND PROCEDURE DIRECTIVES

More often than not, the respective state or territory and Commonwealth departments of health issue numerous policy circulars, many of which are directly relevant to nurses and midwives in their day-to-day work. Such policy circulars very often lay down procedures and practices to be observed and enforced in given clinical situations and are generally issued as a clear indication of the standards to be observed in such situations.

In addition, employers in the health industry put in place a large number of policy and procedure directives designed to ensure that employees follow a safe and recognised standard of clinical practice. Accreditation standards documents are often another source of expected professional clinical standards. Often a plaintiff alleging failure by a nurse or midwife to abide by a particular policy or procedure directive may provide supportive evidence of the standard of care expected in a given situation by referring to such documents. For example, if a hospital procedure manual laid down the strict procedure to be followed in adding prescribed drugs to a patient's IV fluid line, or in the administration of a blood transfusion, then an unreasonable failure or refusal to abide by such procedural directives, with consequent adverse effects on the patient, would clearly place the nurse or midwife in breach of the proper and generally recognised safety standards laid down by the employer. It would also place the nurse or midwife in breach of his or her overall duty of care to the patient because he or she failed to observe proper standards of

care and safety in carrying out professional procedures — the employer's policy and procedure directive would be used as evidence of what constituted competent professional practice, against which the conduct of the nurse or midwife would be judged.

ACADEMIC TEXTS AND PUBLICATIONS

Recognised academic texts relevant to that particular area of healthcare and professional practice under scrutiny may provide the foundation for establishing evidence of widely accepted and competent professional practice.

THE PATIENT'S MEDICAL RECORDS

While the patient's medical records are not documents that, of and by themselves, would be referred to for determining the standard of care expected in a given clinical situation, we mention them in relation to this issue because the patient's medical records will invariably disclose whether or not the clinical care given to the patient did or did not accord with competent professional practice. When 'peer professional opinion' evidence is elicited and policy and procedure protocols are subpoenaed and read, the patient's medical records will be scrutinised to ascertain if the staff involved in the care of the patient, by their actions or omissions, did or did not abide by the expected standard of care expressed by peer opinion or found in policy and procedure protocols of the employer or health service. A patient's medical records contain critical evidence of what treatment, care or advice was given to the patient — or not, as the case may be. For example, all treatment notes, medication order sheets, observation charts, pathology results, radiological reports and all documents relating to the patient's care and treatment will be located in the patient's medical records. Those documents will often be a valuable source of evidence for a healthcare professional in order to demonstrate that the treatment and care given was of a 'professionally competent' standard. Alternatively, they can be a source of evidence for a plaintiff's lawyers who may point to entries in such documents (or the absence thereof) as evidence in support of their allegation of professional negligence. As a consequence, the importance of documentation in the delivery of healthcare is a critical factor of which nurses and midwives should be ever mindful. This subject is addressed in more detail in Chapter 7.

UNDERSTANDING THE APPROACH TO BE TAKEN IN DETERMINING THE PROFESSIONAL STANDARD OF CARE

The best way of obtaining an understanding of how the courts would approach the determination of the standard of care in a professional setting is by examining the outcomes of cases that have come before the courts or come to light during a coroner's inquest where the conduct of nurses and midwives in the performance of their duties has been highlighted. The examples which follow arise in some cases from a formal finding of civil negligence by a relevant court of law. Other examples are derived from a coroner's inquest into the death of a patient. In the case of the latter examples, there is no formal finding of civil or criminal negligence but rather adverse and critical comment by the coroner concerning the actions of the nursing staff, amongst others, leading to the death of the patient.

In many situations concerning the determination or otherwise of negligence in hospital or healthcare situations, the findings of a Coroner's Court are often the first step in the legal process, as the findings and evidence elicited in such inquiries are often used as the basis for a subsequent court action alleging civil or criminal negligence. For that reason, Coroner's Court inquest reports are a valuable source of guidance and assistance in understanding the standard of care expected of nurses and midwives in certain clinical situations.

The majority of the examples arose before the introduction of the civil liability legislation setting out the provisions relevant to determining the standard of care for healthcare professionals (amongst others). That legislative approach does not negate the following case reports as practical examples that would still be relevant in determining whether the standard of care given in a given situation was 'widely accepted' by 'peer professional opinion' as being 'competent professional practice' or otherwise.

EXAMPLE 1: CORONER'S INQUEST INTO THE DEATH OF TRACEY BAXTER

This matter resulted in a coroner's inquest into the death of a child, Tracey Baxter. The incident occurred in a hospital in New South Wales in 1979. The facts of the matter highlight the professional standards expected of nursing staff in caring for children and the keeping of observation records generally.

Facts

A 6-year-old child was admitted to hospital for a routine tonsillectomy. The operation was performed at the commencement of the afternoon list and the child was in the recovery room of the operating theatre at approximately 2.30 pm. Prior to surgery an intravenous line was inserted and during the operation the child received 300 ml of normal saline. At the conclusion of the operation the surgeon wrote on the intravenous fluid order chart that the child was to continue to receive 100 ml per hour of a dextrose/saline solution. The registered nurse in the recovery room commenced an observation chart on the child (Figure 3.1), but not a fluid balance chart. That was commenced by the registered nurse in the children's ward on the child's return (Figure 3.2). The registered nurse in the recovery room, apart from noting some preliminary pulse rate readings, also wrote the initial comment concerning the intravenous fluids to be given to the child. That comment read, amongst other things, that the child was to have 'as much as possible in ward'.

The child was returned to the ward at approximately 3.00 pm and the fluid balance chart was commenced and observations continued. A glance at the fluid balance chart in Figure 3.2 will reveal that at 4.30 pm, some one-and-a-half hours after the child's return to the ward, a further litre of the dextrose/saline solution was commenced. This litre went through by 2.00 am the next day, and a further litre was commenced by the registered nurse on night duty. The fluid balance chart does not reveal when that litre was intended to be completed but it does reveal that by some time later that morning (approximately 9.00 am, as best determined in court) the child had received 700 ml of that litre. The total intravenous fluid intake of the child from the time of the operation to 9.00 am the next morning was

Name: _____ Date: _____

Time	T.P.R	B.P	I.V.I. Fluids	Comments
1430	Pulse 136		I.V.4% Dextrose	Condition
			1/5 N/S To	good
1500	Pulse 130		have 300 Ml in	Bleeding
			Recovery and	NIL
			as much as	
			possible in Ward	
1500	TO WARD			
1515	P120 R20			
1530	P112 R2			sleeping
1600	P120 R20			sleeping
1630	P120 R22			sleeping
1700	P110 R2			sleeping
1730	P100 R20			sleeping
1800	P110 R20		vomited 15ml	sleeping
1830	P112 R20		vomited 15ml	sleeping
1900	P102 R20		vomited 20ml	restless
2200 T36[5]	P120 R22		vomited 15ml	
2300	P98 R20			
2400	P86 R18			
0100	P88 R18			
0130	P86 R16			
0200	P66 R18			
0230	P60 R20			
0600	P60 R20			
0630	P76 R22			
0700	P80			
0800	P86			

OBSERVATIONS

Figure 3.1 Child's observation chart for incident described in example 1

3 litres — remembering the 300 ml of normal saline administered in the operating theatre that was never entered on the fluid balance chart.

The child's observations were continued spasmodically, as the observation chart reveals, and there were occasions when no observations were taken for some hours. A critical examination of the pulse rate in Figure 3.1 shows a slow but steady decline, and a relevant section of the nurse's notes reveals that the child's pulse rate went down to as low as 48 on at least one occasion.

Name: _____ H.M.O. _____ Date: _____

INTAKE					OUTPUT				
	ORAL		INTRAVENOUS						
Time	Substance	Amount	Fluid commenced	Amount completed	Time	Urine	Aspiration	Others	
12mn									
			4% Dextrose						
			⅕						
Commenced in O.T			1000 →		9.45 pm			emesis	10
				1000	10.30			emesis	10
1630			4% Dextrose		11 pm			emesis	10
			⅕ N/S		11PM	P.U.	into bed		
			1000		12.30	P.U.	into bed	emesis	20
12mn				1000	1.45	P.U.	into bed		10
0200			4% Dextrose		0200	P.U.	into bed		10
			⅕ N/S		0400	P.U.	into bed		10
			1000 →		0600	P.U.	into bed		
				700	0630	P.U.	into bed		
					0700	P.U.	into bed		
					0800	P.U.	into bed		
					0900	P.U.	into bed		
					0945	P.U.	into bed		
						Catherterised 450 mL			
12mn									
24 hour total				2700	24 hour total				

Total 24 hr intake: 2700 Total 24 hr output: 475 + +

Figure 3.2 Child's fluid balance chart for incident described in example 1

The following are extracts from the nurse's notes, written by the registered nurse on night duty at various intervals during the night:

> 12.00 am: Patient very distressed twitching; screaming; eyes glazed; vomiting bile; obs. satisfactory. Dr notified. Ordered stat — Maxolon 31/2 mgm IMI given 12.45 am. Voiding well — Maxolon helped only a little. Vomiting continued, but twitchings became less and movements generally became more rational. Pupils still dilated.

> 4.15 am: Child had a fit lasting about 3 minutes, afterwards she had a high pitched wail, her limbs were rigid, her tongue protruded … P48/m. Child has been afebrile throughout. Dr notified.

Following the incident at 4.15 am, the child's doctor came to the hospital and administered IV Valium and IM Dilantin to control the fitting. He also reduced the IV fluid order to 60 ml per hour. In doing this he did not look at the child's fluid balance chart, as he presumed the child had been receiving what he had originally ordered (100 ml per hour). Arrangements were also made for the child to be seen by a specialist consultant later in the morning. This was done but no definite cause for the child's condition could be determined at the time. While investigations were still underway, the child had a cardiac arrest at approximately 10.00 am the same day, from which she never regained consciousness, and she died a few weeks later, the immediate cause of death being bronchopneumonia.

Comment

At the coroner's inquest which followed, the major allegation raised by the relatives' legal representative was that the real cause of the child's death was the excess fluid negligently administered to the child by the nursing staff. It was stated that the excess fluid resulted initially in cerebral oedema with attendant cerebral irritation, eventual grand mal fitting, electrolyte disturbances, cardiac arrhythmia and finally cardiac arrest. Allegations of mismanagement were also levelled against the medical officers involved, because of their failure to detect the fluid overload as the cause of the child's problem and deal with it. Certainly, in the absence of any other extrinsic evidence as to the cause of the child's death and the expert medical evidence presented in support of such a proposition, it would appear that the excess fluid given to the child played a major role in the child's death. Even assuming that it had not, this unhappy episode serves to illustrate very clearly the standard of care expected of nursing staff in such a situation.

In making his formal finding of the manner and cause of death (bronchopneumonia following cerebral hypoxia and cardiac arrest) the coroner was extremely critical of the standard of care delivered by the nursing staff to the child. The areas of criticism can best be examined as outlined below.

The child's fluid intake and the fluid balance chart

There can be no doubt that the child's intravenous fluid intake far exceeded that ordered. The ward staff were obviously guided in their administration of fluid by the comments of the registered nurse in the recovery room to give the child 'as much as possible in ward'.

In comparing what was done on that occasion against the standard that would be considered as 'competent professional practice' by a registered nurse in the same clinical situation, ask yourself the following questions:

- Would it be widely accepted as competent professional practice by peer opinion that a registered nurse would write 'as much as possible in ward' as a patient's IV fluid order?

- Would it be widely accepted as competent professional practice by peer opinion that a registered nurse working in a children's ward would accept such an order as appropriate?
- Would it be widely accepted as competent professional practice by peer opinion that a registered nurse would seek clarification of such an order from the relevant medical officer immediately?
- Would it be widely accepted as competent professional practice by peer opinion that a registered nurse would know the normal daily fluid balance requirements of children?
- Would it be widely accepted as competent professional practice by peer opinion that a registered nurse would know that 3 litres of fluid in 20 hours would be an excessive amount of fluid to give to a child of 6 in most clinical situations?
- If uncertain as to whether or not the IV fluid intake was or was not excessive, would it be widely accepted as competent professional practice by peer opinion that a registered nurse would seek clarification from the relevant medical practitioner?

In our view, the answers to the questions posed are self-evident. Using this example, it is important to appreciate that, as far as the law is concerned, it would be expected that a registered nurse (or midwife) who is nursing children or infants would be aware of the different fluid balance requirements of children. It would not be expected that the precise requirements of every age and weight be known by rote, *but* that a general knowledge of the difference be known which should cause a nurse or midwife to be aware of the need to carefully check the fluid balance regimes of children and, where any doubt existed, that the patient's treating doctor be consulted. It would be argued that a registered nurse or midwife would have received such knowledge as a result of the educational program required to be undertaken to become registered to practise. Accordingly, if a registered nurse or midwife is going to work in a paediatric area, the law would presume as being reasonable and part of his or her professional competence that the nurse or midwife not only has the knowledge but also applies it.

The child's observations and the observation chart

The child's observation chart clearly demonstrates a steady decline in the child's pulse rate as well as comments which state either that the child is 'sleeping' or 'restless'. Such observations and comments have to be compared against the comments in the nurse's report to the effect that the child is 'twitching; screaming; [has] eyes glazed; [is] vomiting bile; obs. satisfactory' and later 'vomiting continued, but twitchings became less — movements generally became more rational. Pupils still dilated'. The chart also shows that observations were not recorded during some periods.

In comparing what was done on that occasion against the standard that would be considered competent professional practice by a registered nurse in the same situation, ask yourself the following questions:

- Would it be widely accepted as competent professional practice by peer opinion that a registered nurse would not only record the child's pulse rate but also note the steady drop in the rate?
- Would it be widely accepted as competent professional practice by peer opinion that a registered nurse would notify the medical officer of the drop in the pulse rate?
- Would it be widely accepted as competent professional practice by peer opinion that a registered nurse would be alarmed or concerned at the signs and symptoms being exhibited by the child — for example, 'pupils still dilated' — bearing in mind she was a post-tonsillectomy patient?

Once again the answers to the questions posed are self-evident. One of the major tasks of nursing staff is to take and record observations on a patient so as to indicate the present state of the patient's clinical condition and of any worsening or improvement in that condition. As a result of such observations, together with other methods of clinical investigation, a patient's treatment and/or medication is generally determined. It goes without saying that a nurse's responsibilities in this area are significant. Important as the taking and recording of a patient's observations are, what is more important is understanding the significance of those observations. Equally, as far as the law is concerned, a registered nurse would, generally speaking, know the significance of the observations she is taking and recording; that is, what is normal and what is abnormal having regard to the patient's condition. Such knowledge would be presumed to have been received as part of the registered nurse's education and training. If the registered nurse is presumed to have such knowledge it must follow, as a matter of commonsense, that, in the presence of abnormal observations, widely accepted professional practice would be that the nurse concerned would notify the appropriate medical officer or senior nursing staff. That is the standard of care that would be expected in such circumstances.

EXAMPLE 2: *SHA CHENG WANG (BY HIS TUTOR RU BO WANG) V CENTRAL SYDNEY AREA HEALTH SERVICE*[30]

This matter dealt with the duty of care involving staff, particularly nursing staff, dealing with people attending the emergency department of hospitals. It examines and comments upon the role of triage nurses in emergency departments. The relevant facts and findings of the court are as set out below.

Facts

The plaintiff, Sha Cheng Wang, was left seriously and permanently disabled by irreversible brain damage as a result of an assault perpetrated upon him in April 1988 as he was walking from the railway station to his home. He was struck from behind by a heavy object and fell to the ground and may have been unconscious for a short period.

He managed to walk to his home, and two of his friends there took him by taxi to Royal Prince Alfred Hospital at Camperdown. They waited for some time in the

Emergency Department, where they were joined by other friends of Mr Wang. After some time, and before Mr Wang had been treated, they left and went to the city Superclinic, which was then on Broadway near Railway Square. There, Mr Wang was treated by Dr Andrew Katelaris and returned home.

In the small hours of the following morning Mr Wang's condition deteriorated and he was taken back to Royal Prince Alfred Hospital by ambulance. It seems that his skull was fractured. He was suffering from extra dural haemorrhage, and surgical intervention at that stage was unable to prevent irreversible brain damage.

In the litigation which followed, the court found Central Sydney Area Health Service liable for Mr Wang's damage because of the actions of the relevant nursing staff in the Emergency Department of Royal Prince Alfred Hospital. In doing so, the judge dismissed allegations of negligence against Dr Katelaris and his employer, Superclinic Australia Pty Ltd.

As the full facts of the matter disclosed, the reason why Mr Wang left the Emergency Department and went elsewhere is because he and his friends became upset and impatient that he was not seen by a doctor within a short time of his arrival at the Emergency Department. They were worried about his condition, he was bleeding from his head wound and very pale, but conscious. Mr Wang had come to the Emergency Department at 9.25 pm and left at approximately 11.00 pm.

In his treatment at Royal Prince Alfred Hospital, Mr Wang was attended to by a registered nurse.

Mr Wang was seen on arrival by the triage nurse, Registered Nurse Carruthers, who obtained a brief history and undertook a brief physical examination of him. Her entry in the patient notes read simply 'assaulted ? LOC' and she explained that the expression '? LOC' meant a possible loss of consciousness. There was no other notation made of any other neurological observations undertaken by Nurse Carruthers, although she gave evidence that, as part of her initial examination of Mr Wang 'he walked into her office unaided and appeared to be alert. She had him squeeze her fingers to test his hand grip, which she found to be firm and equal. She checked his pupils by having him close his eyes and open them quickly, and they appeared to be equal and reacting to light'. It should be noted at this point that the judge hearing the matter concluded that he found the evidence of Nurse Carruthers 'unreliable in certain respects'.[31]

In any event, Nurse Carruthers advised Mr Wang and his companions that the Emergency Department was busy and they would have to wait. There was evidence that Mr Wang's companions later approached Nurse Carruthers on two occasions expressing their concern about him.

At about 10.00 pm, Nurse Carruthers was relieved by Registered Nurse Jennifer Smith. Evidence was given that one of Mr Wang's companions subsequently approached Nurse Smith to inquire how much longer Mr Wang would have to wait to be treated. He was told that the department was busy and that a lot of people were waiting. About 15 minutes later he asked her if they could go somewhere else for treatment, perhaps at a private hospital, and she said that they were free to do so. As he put it, she said that 'we can do whatever we want to'.[32]

A decision was taken to leave the hospital and seek treatment elsewhere. Mr Wang and his friends left at about 11.00 pm and Nurse Smith wrote in the notes 'Did not wait to be seen'.

When Mr Wang and his friends arrived at the Superclinic he was immediately seen by Dr Katelaris. There was no criticism or adverse finding as to the treatment given by Dr Katelaris to Mr Wang as recorded by his clinical notes at the time. That is:

- Dr Katelaris obtained a full history of the assault.
- He examined Mr Wang and took the full range of neurological tests. He found no abnormal signs.
- He examined, cleaned and sutured the head wound and administered a tetanus toxoid injection.
- He advised Mr Wang he should return to the hospital for an X-ray. This was rejected because of the displeasure at what had occurred earlier.
- Dr Katelaris gave them a 'head injury advice form' and went on to explain what it said, using gestures to ensure that he was understood. He said that an ambulance should be called immediately in the event of vomiting or convulsion, if the plaintiff became drowsy or unrouseable, or if they observed weakness in one or more of his limbs or inequality in the size of his pupils. He told them that the plaintiff should not be left alone. He advised them to take him to a Chinese-speaking doctor the next morning to arrange for an X-ray and for any ongoing care which might be necessary.

Mr Wang went home to the flat that he shared with his friends. During the night Mr Wang started vomiting and convulsing and became unconscious. An ambulance was called and Mr Wang arrived back at Royal Prince Alfred Hospital by 4.00 am and underwent surgery, but was left with irreversible brain damage.

Comment

Mr Wang's case against the hospital was put on two alternative bases. Firstly, it was alleged that Nurse Carruthers' examination was inadequate and superficial and that no notice was taken of his friends' insistence that Mr Wang needed urgent attention, so that Mr Wang was not afforded the priority which he deserved. Alternatively, accepting that his priority was appropriately assessed, Nurse Carruthers should have consulted a doctor about him before she went off duty and Nurse Smith should have done so before the plaintiff left the hospital. In either event, it was said, some attempt should have been made to dissuade Mr Wang from leaving before he had been seen by a doctor.

The judge was critical of the actions of both nurses in the terms as expressed above — particularly Nurse Smith, who did not give any evidence. On the role of the triage nurse the judge made the following comment:

> … it is clear that her task as triage sister was to make a primary assessment of him with a view to assessing the urgency of his need for the treatment. That assessment had to be made in the light of the other demands upon the Department at the time and the available professional resources … Sister

> Carruthers' other responsibility was to keep the plaintiff under observation in the waiting area in case his condition worsened.[33]

It is clear that Nurse Carruthers gave an oral report to Nurse Smith at the end of her shift. Mr Wang's friends continued to request that he be seen by a doctor only to be met by the statement from Nurse Carruthers and Nurse Smith that the Emergency Department was busy and they would have to wait. Eventually one of Mr Wang's friends, a Mr Ng, inquired as to whether they should seek treatment elsewhere. On that issue, the judge stated:

> I turn, then, to the question which has troubled me most. Should hospital staff have attempted to dissuade the plaintiff from leaving? I have referred (at para 21) to the unchallenged evidence of David Ng about his inquiry whether they might seek treatment elsewhere. I am satisfied that that inquiry was directed to Sister Smith and that she did not advise them to wait. It is true that some further time elapsed before they left, and counsel for the hospital submitted that the staff might have not been aware of their departure. However, if appropriate observation of the plaintiff in the waiting area were being maintained, they should have been.
>
> It was common ground that the plaintiff was free to leave and the hospital staff had no power to restrain him. However, varying views were expressed by the experts about how the situation should have been handled. Ms Fares said that normally staff would attempt to persuade a patient from leaving and would find out how soon a doctor might be available, informing the medical staff that the patient was becoming restless.[34]

Another expert medical witness accepted by the judge gave evidence that:

> … when patients decide to leave an emergency department without treatment, staff should attempt to discourage them from doing so. Failing that, they should try to ensure that they seek alternative medical care. The practice in the hospital where he worked was that, if it was clear that a patient could not be persuaded to wait, he or she would be given the names of medical clinics in the area … the approach of staff to the situation must be flexible and would depend on a number of variables, including the clinical presentation of the patient, where the patient intended to go upon leaving, the demands upon the resources of the department at the time, the availability of other medical services in the area and their capacity to deal with the patient's condition.[35]

In considering the circumstances in which Mr Wang left the Emergency Department, the judge came to the conclusion that the Central Sydney Area Health Service was liable for Mr Wang's permanent damage, because of the failure of the triage nurses in Royal Prince Alfred Hospital to properly observe him and advise him against leaving the hospital. In determining that liability the judge concluded:

> Given the unpredictable effects of head injuries, it was clearly in the plaintiff's best interests to remain at the hospital, where there were the

> resources to observe and respond to any deterioration of his condition. I am satisfied that, if he had, he would not be in his present predicament.
>
> Sister Smith did not ask Mr Ng where they intended to go, and did not offer any advice about alternative sources of treatment suitable for the plaintiff's condition, should it deteriorate. Indeed there is no evidence that there was any suitable source at that time of night other than a public hospital. Sister Smith should have counselled the plaintiff to remain at the hospital, explaining why it was in his interests to do so.
>
> … Clearly, the primary duty which the hospital owed to the plaintiff was to assign him his appropriate priority through the triage system and to observe him in the waiting area in case his condition deteriorated.
>
> The Central Sydney Area Health Service, which administers the hospital, is a statutory authority whose duty was to take reasonable care for the plaintiff's well-being in the circumstances, within the limits of its resources. In my view, that duty extended to furnishing the plaintiff with appropriate advice when it was intimated that he might leave the hospital. The hospital failed to discharge that duty, and the plaintiff's present condition is attributable to that failure.[36]

The question as to whether Mr Wang and his friends would have accepted the advice to remain at the hospital if spoken to in those terms had to be determined. Mr Wang was unable to say because of his incapacity. The judge did consider the evidence of his friends who were with him on the night in question and came to the view, on that evidence, that he would have.

EXAMPLE 3: *MCCABE V AUBURN DISTRICT HOSPITAL*[37]

This case is a very good illustration of how the death of a person in hospital can give rise to a coroner's inquest into the manner and cause of death and, subsequently, a civil action alleging negligence on the part of the medical and nursing staff involved in the person's care.

The incident giving rise to this decision occurred in a public hospital in New South Wales in 1981. The case is also referred to in Chapter 7 to highlight the importance of proper record-keeping by nursing staff.

The relevant facts are set out below.

Facts

Mr McCabe was a 21-year-old man admitted to hospital for an emergency appendicectomy. Post-operatively he did not make the expected uneventful recovery. He could not keep food or fluids down, he developed diarrhoea and a spiking temperature pattern, and he complained of excessive abdominal pain. A chest X-ray and a microurine were ordered and proved negative. On the morning of the fifth post-operative day, which was a Saturday, the registrar was doing his rounds prior to going off duty but remaining on call at home over the weekend. The patient was still exhibiting the same symptoms. The registrar ordered a full blood count to be

done that morning. The blood was taken and the result returned to the ward that afternoon after the registrar had left the hospital. The result disclosed a significantly raised white cell count and other abnormal readings indicative of some form of severe infection. The registered nurse on duty filed the pathology result in the appropriate place in the patient's record and did not attempt to contact the registrar. Likewise, at no time during the weekend did the registrar ring the ward to ascertain Mr McCabe's results. None of the other registered nurses who came on duty that weekend noticed the pathology result.

Not only were the nursing reports written separately from the medical officers, but the nursing staff who came and went over the weekend relied on the verbal handover report received at the commencement of each shift.

The result did not come to light until Monday afternoon when the patient's condition was considerably worse. The patient was immediately placed on IV antibiotics and was subsequently returned to theatre for an exploratory operation and found to have widespread peritonitis. He died a few days later after succumbing to renal failure.

The young man's mother sued the hospital and the hospital staff for negligence in the care of her son and sought compensation for loss of income dependence under the *Compensation to Relatives Act 1897* (NSW) as well as nervous shock. On the basis of the facts as outlined above, and the evidence presented, the judge upheld Mrs McCabe's claim against the hospital and its staff. The hospital acknowledged their vicarious liability for the actions of its medical and nursing staff at the outset of the case.

In arriving at his conclusion of negligence on the part of the hospital and its staff the judge saw fit to make critical comment on the accuracy and reliability of the medical and nursing notes particularly having regard to evidence given by other patients and Mr McCabe's friends and relatives as to his deteriorating condition. The following extracts on this issue appear in his Honour's judgment:

> I am of the view that the hospital notes are not, in the current case, reliable. In particular there is unreliability in recording the manifest and observable continuing deterioration of the deceased's condition. I am satisfied that the routine temperature checks even if accurate as to scale were accompanied by failure to note what was there to be seen, namely that the deceased was perspirant and 'hot'. This was evident even to non-medical appreciation … I do conclude … that there were things significant in assessing the patient's deterioration which were overlooked and the written record simply does not truly reflect the currency of events.[38]

And further:

> It follows that the ability of the (medical staff) to perceive the deterioration in the patient's condition was inhibited by the inadequacy of the clinical and nursing notes.[39]

And again:

> It would be apparent from my earlier findings and remarks that I conclude that the clinical and nursing notes were deficient. Their inadequacy must

> have been a major factor in bringing about a situation which allowed the patient's condition to deteriorate fatally without timely remedial treatment.[40]

Comment

The above comments and findings by the judge emphasise the standard that the law would expect of nursing staff in the accurate and timely recording of a patient's observations and overall clinical condition.

However, in our view, the sequence of events that arose in the care of Mr McCabe does raise the important question of whether or not the standard of care expected of the ordinary reasonable competent registered nurse in the performance of his or her duties would extend to notifying the medical officer of abnormal pathology results, or indeed of any pathology results. The answer, as always in such a situation, would depend on the facts and circumstances, supported or otherwise by expert opinion from professional nursing peers as well as any relevant nursing policies or protocols in place in the health service or hospital.

There is no doubt that registered nursing staff in particular, as part of their study of normal and abnormal pathology, are familiar with a wide range of commonly used clinical and biochemical indicators of the abnormal. In the more highly complex and technical areas of medicine, that would not necessarily be so. However, in the incident described in this example, it would, we suggest, be readily conceded that a registered nurse would recognise an abnormal white cell count and appreciate its significance, to the extent that it was probably indicative of some type of severe infection. The fact that a pathology result is abnormal does not of itself signify the necessity for somebody to be contacted immediately, as many patients in hospital will routinely show abnormal pathology results as part of their disease process.

What is probably significant in considering this issue is the reason why, and the circumstances in which, a particular pathology test is ordered. In the normal situation, pathology tests are ordered as deemed necessary by the patient's medical practitioner, and the results of such tests are returned to the medical practitioner. In hospitals, pathology results are routinely screened on a Monday-to-Friday basis by the medical officers concerned, as they are returned. On weekends or night duty, when medical officers are rostered on call for emergencies only, it is not uncommon for them to be contacted by nursing staff to relay abnormal pathology results following tests that have been ordered to be done during the night or on weekends for a variety of reasons. As a consequence of the pathology result, it may be necessary for the medical officer to initiate treatment and/or medication or make a change to the patient's treatment and/or medication. In the latter situation it would be difficult for a registered nurse to argue that the standard of care expected of them did not extend to notifying the medical officer concerned of pathology results that the nurse knew to be abnormal, when they knew the medical officer would otherwise not receive them for some time, and when the tests had been ordered to be taken at a time when the medical officer would not normally be present to receive the result.

As indicated earlier, each situation would be determined having regard to its own particular facts and circumstances, but if a nurse is faced with such a situation any

doubts should be resolved by notifying the result to the relevant medical officer. Obviously, notifying the result should be accompanied by an entry to that effect in the patient's record.

In hospitals, procedural guidelines may assist in resolving the majority of problems which arise in this type of situation.

EXAMPLE 4: *NORTON V ARGONAUT INSURANCE COMPANY*[41]

This example occurred in Louisiana in the United States some years ago but imparts a significant lesson to all nurses concerning the standard of care expected in the administration of medication.

Facts

A 3-month-old infant was admitted to the paediatric ward of a hospital for investigation and treatment for congenital heart disease. On admission his medical practitioner wrote the following medication order on the patient's medication sheet:

> Elixir Paediatric Lanoxin 2.5 cc
>
> [0.125 mg] 6qh x 3 then once daily.

The child remained an in-patient for a couple of weeks and received the medication of Paediatric Lanoxin elixir as ordered.

One day, the medical practitioner examined the child and changed the medication order for the Lanoxin to one dose only and he wrote the change of order in the patient's record as follows:

> Give 3.0 cc Lanoxin today for 1 dose only.

On the day on which the order was changed, the paediatric ward was particularly busy, with only one registered nurse and one enrolled nurse on duty. Mrs Evans was a registered nurse as well as the assistant director of nursing on duty that day. As part of her responsibilities she was required to provide assistance to ward staff when necessary. On this particular day, she went to the paediatric ward to assist and while checking the patient's records she noticed the change of order for 3 cc of Lanoxin, in which the form of medication or route of administration had not been specified. The medication had not been given, so Mrs Evans decided to administer it herself. Although a registered nurse for many years, she had been out of clinical nursing for some time and she was unaware that Lanoxin was manufactured in elixir form as well as injectable form. Recognising that 3 cc was a large dose to be given intramuscularly, Mrs Evans did consult two other doctors who were present in the ward at the time about the medical practitioner's order. They were unable to assist, as neither was the child's doctor. They advised that she should follow the written instructions. At no time did Mrs Evans contact the child's doctor. Mrs Evans then made a decision to give the child 3 cc of intramuscular Lanoxin, which was five times the strength of the paediatric elixir. A little over one hour after receiving the injection the child died.

The child's parents brought an action against the hospital and the doctor for negligence. The court determined that the doctor was negligent for writing an

unclear medication order. The court also found that Mrs Evans failed to meet the standard of care required of a registered nurse and said:

> As laudable as her instructions are conceded to have been on the occasion in question, her unfamiliarity with the drug was a contributing factor in the child's death. In this regard we are of the opinion that she was negligent in attempting to administer a drug with which she was not familiar … *Not only was Mrs Evans unfamiliar with the medicine in question but she also violated what has been shown to be the rule generally practised by the members of the nursing profession in the community … namely, the practice of calling the prescribing physician when in doubt about an order for medication.*[42] [emphasis added]

Comment

The lesson to be learned from the above example is that any nurse or midwife who is uncertain about a medication order must take all reasonable steps to contact the prescribing doctor for clarification. If a reasonable effort fails to locate the prescribing doctor, the nurse or midwife should seek the assistance of a person able to assist or give appropriate directions; for example, a clinical manager, supervisor, another doctor familiar with the patient or an administrator able to obtain the assistance of another doctor. In hospitals with pharmacies, the pharmacist may be able to help a nurse or midwife resolve conflicts over drug dosages. However, such an avenue should be pursued only when all efforts to locate the patient's medical practitioner have failed. To overcome difficulties of this kind, hospitals should have very clear guidelines as to what steps staff should take in order to clarify a medication order if the patient's medical practitioner cannot be contacted within a reasonable time.

EXAMPLE 5: *ISON V NORTHERN RIVERS AREA HEALTH SERVICE*[43]

This matter arose as an application for the reinstatement of the applicant to the position of Clinical Nurse Consultant in Women's Health with the Northern Rivers Area Health Service. However, the facts of the matter and the findings made by the court bear specifically upon the standard of care expected of a registered nurse acting in the position of Women's Health Nurse.

Facts

Nurse Ison commenced employment in February 1987 as a Clinical Nurse Consultant with the Northern Rivers Area Health Service based in northern New South Wales.

Her major responsibility in that position was the taking of Pap smears from patients who attended the clinics she conducted, forwarding those smears to the Pathology Department of Westmead Hospital in Sydney and receiving the results back from that hospital and notifying the clients of those results. It was also her responsibility to maintain various medical records in relation to those activities including the Pap Smear Register. As a result of a complaint made by a client of Nurse Ison's in 1995, an investigation revealed that there were 18 different cases wherein Nurse Ison had failed to notify clients of Pap smear results where that notification should have been made. There were a further five cases where there was

a failure to notify particular clients of the need to attend for a re-smear because of some uncertainty in the original Pap smear result and there were additionally 20 files that had been randomly extracted by the employer that demonstrated poor documentation of clients' medical records kept by Nurse Ison.

As a result of all of those matters and a general dissatisfaction in Nurse Ison's performance as a Clinical Nurse Consultant in Women's Health, she was dismissed from her employment in December 1995. Nurse Ison disputed that decision and sought her reinstatement before the Industrial Relations Court of Australia. She was unsuccessful in that application on the basis that she had been treated fairly in the way in which her employer had gone about investigating the complaints made about her work and then procedurally dealing with those matters as well as giving her the opportunity to respond to the allegations.

At the outset it should be said that Nurse Ison did not, by and large, dispute the nature of the complaints made against her as detailed above. Instead she raised in her defence the fact that she found herself, as she perceived it, operating in circumstances where she needed additional assistance to help her do her job and that she was doing the best she could in all the circumstances. That was not a view that was supported by the court and, in coming to the view they did, the court made a number of findings relevant to the question of the standard of care that would have and should have been expected of Nurse Ison in her position.

It was conceded on behalf of Nurse Ison that the status of Clinical Nurse Consultant is the highest rank a nurse practitioner could achieve in clinical nursing in New South Wales, requiring and providing as it did an advanced level of nursing practice involving a senior level of knowledge, initiative, responsibility and accountability. There was evidence that Nurse Ison operated in an autonomous fashion as a sole practitioner in the field of women's health in her geographical area.

It was stated by Nurse Ison that when she first commenced in the position, in relation to the taking of Pap smears between 1987 until 1994, she advised her clients in the following terms:

> If you don't hear from me regarding your Pap smear result, everything is okay. If I need to contact you about your Pap smear for reassessing it to be unsatisfactory, I will do so by telephone or letter. The results will take 3 or 4 weeks to return to me.[44]

It would seem that from 1994 onwards, as a result of some procedural changes concerning both the categorisation of Pap smear results and the steps to be taken as to the notification of those results, Nurse Ison advised her clients in words to the effect of:

> I will contact you by letter if your Pap smear is fine. If not I will be contacting you by phone.[45]

The problem seems to be that, while that may well have been the intention of Nurse Ison, she did not observe that procedural standard and also failed to properly maintain her clinical records. For example, one of the clients who attended Nurse Ison at her clinic told the court that she first attended the Women's Health Clinic in April 1994 and Nurse Ison had performed a Pap smear. At that time the client

had taken with her a letter from her specialist gynaecologist outlining her previous history that had stated, relevantly, that she had been treated in 1993 for a CIN lesion of the cervix using radical diathermy and advising that any recurrence of abnormal smears would need to be investigated by colposcopy.

This client told the court that, at the time she attended the clinic, Nurse Ison had told her that she would be notified 'either way' of her Pap smear results if there was something abnormal or that she would get a letter in the mail. Suffice to say that the particular client heard nothing despite making both verbal and telephone inquiries to the applicant in 1994 and in 1995. Indeed the client attended the clinic in June 1995 for a further Pap smear consultation and when she inquired as to her last Pap smear results she was told by Nurse Ison that 'it was fine'. Again the client was told that the same procedure would apply; that is, if there was a problem, Nurse Ison would contact her personally and that otherwise notification would be by letter.

The client heard nothing until she was contacted by another nurse in July 1996 advising her that her Pap smear result had come back showing inflammation and suggesting that she should see a gynaecologist. Further inquiries by the client at that time via her general practitioner alerted her to the fact that there had been a problem with the result of her 1994 smear. As the court heard:

> … [the client] was horrified at what she had learned and promptly visited her own gynaecologist and had treatment … she was extremely emotional and was of the opinion that 'she was going to die'.[46]

That particular client's experiences and the failure to notify her of her Pap smear results became the initial complaint against Nurse Ison.

There was evidence given in the course of the case seeking Nurse Ison's reinstatement that this particular client had commenced civil litigation against the Area Health Service relying on the negligence of Nurse Ison as their employee. It was disclosed during the course of the reinstatement hearing that the civil litigation had been settled in favour of the client.

When the extent and scale of Nurse Ison's failure to record and properly advise clients of Pap smear results became evident, and when proper investigations had been undertaken by her employer, her services were ultimately terminated.

Comment

In the hearing to consider her application for reinstatement, and having regard to all of the evidence as to the actions of Nurse Ison over a period of time in her position as Women's Health Nurse, the court had this to say:

> Having considered the protocols in place at the time … it is a finding of this court that the applicant would have been more than aware of her direct and personal responsibility to both maintain correct and current medical records, and to notify women clients of health threatening pap smear results. Further, that obligation fell directly to her. The evidence shows that in addition to not following the set protocols, on occasion, the applicant failed to follow her own methodology regarding notification procedures. Mr Schofield described a sole practitioner is (sic) one who works unaided,

> without the assistance of another medical officer along side. It is my view that implicit in that definition is the understanding that the sole practitioner would be capable of applying all relevant regulations and requirements pertaining to that particular profession, and in that regard the applicant should have been capable of maintaining a correct filing system, with due attention paid to the correct recording of pathology results. The evidence did not bear that out. The court heard evidence of files entitled 'lost files', 'lost reports' and 'to contact', illustrating a less than professional approach to the serious responsibility personal to her.[47]

On the issue of whether or not Nurse Ison had sufficient resources and facilities to enable her to do her job according to the standard expected, the court had this to say:

> Ms Ison had access to sufficient facilities to enable a better standard of client notification be maintained than the one she in fact maintained during the course of her employment. A review was conducted by her employer of a large sample of files. No evidence was produced indicating other women's health nurses failed as Ms Ison did to meet the standards set in the various protocols.[48]

In short, the court found:

> … the actions of Ms Ison did not fall solely into the category of 'errors of judgment' but neglect of duty on several occasions which potentially could be life threatening to the women patients and accordingly it is the finding of this court that the employer did have a valid reason to terminate Ms Ison.[49]

EXAMPLE 6: *LANGLEY V GLANDORE PTY LTD (IN LIQUIDATION)*[50]

The history of this matter is somewhat unusual, but it serves as a very good example of the standard expected of nurses in operating theatres. In coming to their decision the Court of Appeal judges made specific reference to the Australian Council of Operating Room Nurses (ACORN) Standards for nurses working in operating theatres.

Facts

The background to this matter concerns a woman who was operated on for an abdominal hysterectomy at Mt Isa, Queensland, in February 1990. After the operation it became apparent, as a result of certain symptoms suffered by the woman, that a surgical sponge had been left inside her abdomen. The painful symptoms manifesting this fact were such that she was required to undergo a further operation some 10 months after the first operation to have that sponge removed. The woman sued the doctor who performed the operation as well as his assistant, and also sued the private hospital in Mt Isa, who operated under the corporate name of Glandore Pty Ltd, as the employers of the nursing staff who assisted at the operation.

When the matter came for hearing in the first instance it was heard before a judge with a jury. Juries in civil actions are rare. In most states and territories of Australia, with the exception of defamation cases, there is generally little provision for juries in civil matters. However, in this case there was. It was their task after they had heard all the evidence to determine who, of all of the parties sued by the woman, had been negligent in leaving the sponge in her abdomen. The jury found that the doctor and his assistant had been negligent but the nursing staff, regarding their responsibility for counting sponges, had not been negligent.

The two doctors who had been found negligent believed that the decision of the jury was contrary to all of the evidence that had been given, particularly in relation to the nurses' responsibility for the checking and counting of sponges. They argued that the jury verdict was perverse, unreasonable and contrary to all of the evidence considered in its totality. The two doctors appealed against the decision, arguing that the employer of the nurses, Glandore Pty Ltd, should be made vicariously liable for the negligent actions of the nurses in this matter.

Comment

In delivering the judgment, the Court of Appeal agreed with the argument of the two doctors and upheld their appeal. In doing so, the court found that the nurses had been negligent by failing to properly account for and record the number of sponges used during the operation. In coming to that view, the Court of Appeal said, relevantly, as follows:

> At the trial it was not in contest that it was as a result of negligence on the part of one or other of those involved in the operation, that the sponge had been left inside the patient's body, and it was not in contest and it could hardly have been contested that an incorrect count had been made by the nurses … the nurses clearly, under the procedure described, had the primary responsibility for making an accurate count to ensure that all of the sponges used had been recovered from the plaintiff's body …
>
> The relevant established standard for 'counting of sponges, swabs, instruments and needles' is called the 'ACORN' standard and it supports the description of the duties that has been outlined above … At the trial, Nurse Kirvisneimi accepted that she and her fellow nurse had made a counting error and she was unable to suggest how it had occurred. None of the witnesses had a recollection of anything untoward occurring in the course of the operation.[51]

A suggestion made in the course of the initial hearing before the judge and jury was that an emergency may have arisen that could have justifiably distracted the nurses from their counting duties. But as the court found, there was no support for this in the evidence. As the court stated:

> … if some emergency, of which there was no evidence, had called for an urgent supply of sponges, the nurses were not relieved of the duty of maintaining an accurate count. It was accepted that if their count was interrupted, they were to recommence it at the point where they had left it.[52]

The court found that Dr Langley, as the main surgeon in the case, had been negligent in that he had failed to retrieve the sponge at the conclusion of the operation and had failed to identify from the plaintiff's continuing symptoms that a foreign object had been left inside her body. The court did not accept that he should bear the full and total responsibility for what was clearly the responsibility of the nurses during the operation; that is, the proper recording and accounting for the sponges used in the operation. Accordingly, the Court of Appeal overturned the decision of the jury because they said that the evidence 'in its totality preponderates so strongly against the conclusion favoured by the jury that it can be said that the verdict is such as reasonable jurors could not reach'.[53] In coming to that decision the court said that the nurses had been negligent in that they had:

> … failed to identify the fact that an abdominal pack had been left inside the plaintiff at the conclusion of the surgery.[54]

As a result of that finding, the Court of Appeal allocated a proportion of the damages against the nurses' employer.

EXAMPLE 7: *ELLIOTT V BICKERSTAFF*[55]

The facts of this case are not dissimilar to the one immediately above involving as it did a swab left inside a patient following a hysterectomy and colo-suspension.

At the initial trial of the matter, the judge said that while the surgeon, Dr Elliott, had not been personally negligent, he should be held liable for the negligent act of leaving the sponge in the patient because he was responsible for the overall care of the patient and he could not delegate that responsibility.

Dr Elliott appealed that decision and argued that he should not be made liable for the negligent actions of the nursing staff in the checking and accounting for sponges and that he was entitled to rely on the theatre staff when they told him the count was correct. There was evidence of his routine procedure in such operations in the following terms:

> Dr Elliott, whilst frankly conceding that he has no independent recollection of the hysterectomy performed on the 13 June 1991, gave evidence as to the invariable procedures followed and insisted upon by him during the course of his surgical career. He said that a record is made of instruments, swabs and surgical sponges available prior to the commencement of any surgery. The responsibility for recording the relevant details rests upon the Theatre Sister who is, of course, an employee of the hospital, not of Dr Elliott. After completing the surgical procedure and before closing the peritoneum, Dr Elliott's practice was to remove the retractors used in the operation manually, explore the abdominal cavity for any swab or surgical sponge and require confirmation by the Theatre Sister that all instruments, swabs and sponges were accounted for. After closing the peritoneum and before closing the patient's skin, Dr Elliott said that his practice was again to require the Theatre Sister to confirm that instruments, swabs and sponges had been accounted for. There is no reason to suppose that Dr Elliott failed on the 13 June 1991

> to follow his normal procedures. It is however, to be inferred that there was a miscount or error by the Theatre Sister or a nurse subservient to her which resulted in unfounded assurances being given to Dr Elliott.[56]

The court accepted that the above procedure was one that Dr Elliott would have followed on the day in question. Certainly there was no evidence to suggest otherwise. On that issue the court concluded that Dr Elliott:

> … did not undertake the provision of nursing services before or after the operation; they were to be provided by the hospital.[57]

Accordingly, the court found:

> … [Dr Elliott] was entitled to rely on the theatre staff in the customary way, and on the evidence in this case I do not think that his duty of care relevantly extended beyond feeling for sponges in the abdominal cavity and asking whether the sponge count was satisfactory. It follows that in my opinion, Dr Elliott was not in breach of a non-delegable duty of care by reason of the negligence of the theatre staff.
>
> In the manner in which surgery of the kind undergone by the respondent is performed, the patient receives the attention of a team: the surgeon, the anaesthetist, and theatre staff. There is divided responsibility. The surgeon can be regarded, in the phrase used by the respondent's counsel, as the master of ceremonies, but he is nonetheless a member of a team and reliant on the due discharge of their responsibilities by the other members of the team. He should be able to concentrate on his own skilled task without shouldering the responsibilities of other members of the team.[58]

Comment

The two cases immediately above highlight the independent professional responsibility of nurses and midwives to maintain their clinical competence notwithstanding that they may be working in a team environment. It cannot be expected, as a general proposition, that a medical officer be professionally and therefore legally responsible for ensuring that the clinical standards of the nurse or midwife working alongside him or her is in accordance with competent professional nursing or midwifery practice. As always it would depend on the facts and circumstances of the situation under review.

EXAMPLE 8: CORONER'S INQUEST INTO THE DEATH OF SAMARA LEA HOY[59]

This matter concerns the death of a child shortly after birth and focuses on the actions of the midwives and the obstetrician involved in the care of the child's mother during labour and the resultant death of the child shortly after birth.

The child, Samara Lea Hoy, was born on 8 November 2008 at the John Flynn Hospital in Queensland. The child was delivered by Ventouse extraction after a prolonged second stage labour and died shortly after birth. Because of the circumstances surrounding the death of the child it was a 'reportable death' and a coroner's inquest was necessary.

During her pregnancy Mrs Hoy had been managed by her obstetrician, Dr Trueman. Her pregnancy was largely uneventful and according to the evidence given at the inquest, 'Mrs Hoy did not discuss with Dr Trueman the question of assisted birth or intervention'. She did attend antenatal classes facilitated by one of the midwives where natural birth was emphasised as the preferred method of delivery.

Mrs Hoy presented at the hospital at 6.15 pm on 7 November 2008 in established labour. It was a weekend. Dr Trueman was not on call and his patients were being cared for that weekend by Dr Doolabh. Prior to 7 November 2008 Dr Doolabh had never met Mrs Hoy. He did see Mrs Hoy at about 7.00 pm shortly after her admission to the hospital and then left to go home and be on call as required.

On admission Midwife Fennell undertook a baseline CTG for 'less than five minutes'. This was in breach of the hospital's policy dealing with 'Assessment and Management of First Stage of Labour' which required the admitting midwife, Midwife Fennell, to obtain a baseline CTG observation for a minimum of 10 minutes. As well, during the inquest, Midwife Fennell and the midwife in charge at the time, Midwife Peller, accepted that a period of 20 minutes or more was required to obtain a good 'reassuring' CTG trace. There was some evidence that Mrs Hoy was not comfortable with the CTG monitor and it was removed shortly after her admission. On that point, according to the coroner:

> Mrs Hoy said in her evidence that she was not encouraged to continue with the CTG. I am prepared to accept Mrs Hoy's evidence that she was not told the CTG was necessary for the welfare of the baby. Midwife Fennell failed to record Mrs Hoy's refusal to continue with the CTG.
>
> I find that if it had been explained to Mrs Hoy that a CTG was necessary to assess the on going welfare of her baby, she would have had no hesitation of (sic) accepting any discomfort of the CTG and adopted the procedure.[60]

The clinical guidelines adopted by the hospital required CTG monitoring to be undertaken in the presence of certain risk factors. The partogram completed by Midwife Peller during the evening indicated a rising base line in the baby's foetal heart rate from the time of Mrs Hoy's admission from 125 bpm at 6.30 pm to 140 bpm at 9.30 pm and 150 bpm at 10.00 pm. Despite that, no steps were taken by the midwives to undertake continuous CTG monitoring despite the monitor being readily available in the labour ward and despite the midwives attending to Mrs Hoy that evening agreeing, at the inquest, that foetal tachycardia was one of the indicators that triggered the need for continuous CTG monitoring.

At 10.30 pm, Midwife Fankhauser took over the care of Mrs Hoy. No foetal heart rate monitoring had been undertaken between 10.00 pm and 10.30 pm. At 10.30 pm Midwife Fankhauser was aware that Mrs Hoy was fully dilated and in the second stage of labour. The foetal heart rate was noted to be 170 bpm. Midwife Fankhauser noted that recording on the second stage document but charted the foetal heart rate at less than 145 bpm on the partogram. No other foetal heart rate recordings were charted after that time despite the hospital's policy requiring this to be done. In considering Midwife Fankhauser's actions at this point, the coroner said:

> The foetal heart rate, as recorded by Midwife Fankhauser at 10.30 pm, when noted against the rising base line on the partogram graph, indicated a clear need to undertake continuous CTG monitoring and inform the obstetrician. This was not done. The assessment and management of second stage labour policy required a continuous CTG to be undertaken in cases of foetal heart recordings above 160 bpm. Midwife Fankhauser failed to do this … [and] failed to follow the normal labour/use of partogram policy. She failed to accurately record the foetal heart rate recordings taken at 10.30 pm or thereafter record the foetal heart rate measurements as required.[61]

The coroner further commented on Midwife Fankhauser's actions that evening as follows:

> Another cause for concern was Mrs Hoy's slow progress. This gave another reason for continuous CTG. Given … that Mrs Hoy had no sign of progress after one hour in the second stage, and the policy of the hospital dictated that the obstetrician should be called in such cases; given the rising foetal heart rate trend as recorded on the partogram and witnessed by Fankhauser, there could be no other conclusion that a continuous CTG monitoring should have been undertaken at 11.30 pm or prior. The above facts cause me to conclude Midwife Fankhauser was derelict in her duty as a midwife. At about midnight, Midwife Fankhauser noted the presence of meconium. This is a sign of foetal distress and again warranted the use of a continuous CTG in accordance with the hospital policy … There was a systemic break down in the managing of Mrs Hoy's labour … Failure to adequately monitor the foetal heart rate was more than likely a cause of death for baby Samara. Had CTG monitoring been utilised and the partogram completed, as required, in all probability intervention may have resulted in the safe delivery of Samara.[62]

The professional failures of Midwife Fankhauser in particular were compounded by the actions of Dr Doolabh when he was finally called at midnight. He attended the hospital at approximately 12.15 am. He did not undertake any vaginal examination of Mrs Hoy who by this time had been in second-stage labour for two hours without progress. According to the evidence, Dr Doolabh adopted a 'wait and see' approach with no CTG monitoring and did not attempt to deliver the baby until 1.40 am. He did so with some difficulty by Ventouse extraction at 1.45 am. At birth, the umbilical cord was wrapped tightly around the baby's neck and she was covered with thick meconium. She was pale and hypotonic, her foetal heart rate had dropped to 40 bpm and she had no spontaneous respiration. Resuscitation was attempted but was unsuccessful.

In handing down his findings as to the manner and cause of death — birth asphyxia due to a tight umbilical cord around the baby's neck — the coroner was scathing in his criticism of the midwifery staff, Midwife Fankhauser in particular, as well as Dr Doolabh. He found as follows:

1) Mrs Hoy was not adequately monitored during labour; in particular, there was a failure to commence a continuous CTG monitoring much earlier than was done.

2) The maintenance of medical records was 'woefully inadequate'. Information which was required to be recorded was not and recordings of the foetal heart rate were not made as required and in accordance with hospital policy.
3) There was a delay in calling Dr Doolabh. He should have been called at 10.30 pm.
4) The delay in calling Dr Doolabh when signs of foetal distress were evident and when a delivery would have been made much earlier 'did contribute to the death of baby Samara'.
5) Dr Doolabh's response when he was called was inadequate, and as said by his own peers, substandard.

In relation to Midwife Fankhauser, the coroner said:

> Midwife Fankhauser's management of Mrs Hoy's labour was inadequate … there is a sufficient body of evidence to warrant her conduct be reviewed … [and] which might cause a disciplinary body to conclude that she failed to provide Mrs Hoy with an adequate standard of care. The disciplinary board could also conclude that any attempt by Midwife Fankhauser to deliberately alter the records and in turn mislead the Court indicates that she is not a fit and proper person to be registered. Accordingly, I direct the material gathered during these proceedings be referred to the Nursing and Midwifery Board of Australia for its consideration.[63]

In addition to referring Midwife Fankhauser's actions to the registration authority, the coroner further considered the actions of Midwife Fankhauser in deliberately altering the patient's labour progress notes. During the inquest, Midwife Fankhauser admitted that a record of observations initially recorded by her as being taken at 10.30 pm were altered by her some six hours after the child's death to make it appear that the observations were taken at 11.30 pm. On that issue, the coroner referred Midwife Fankhauser's action to the Director of Public Prosecutions (DPP) in Queensland for consideration as to whether she should be charged with the criminal offence of perverting the course of justice. At the time of going to press, no final decision had been taken by the DPP.

The actions of Dr Doolabh in the care of Mrs Hoy were also referred to his professional registration body, the Medical Board of Australia.

Comment

This matter demonstrates very clearly how hospital or health service policies in relation to the delivery of care are not documents that can, or should, be ignored by staff. They are there for a good reason and invariably, when the care of a patient is being carefully scrutinised by a court, the policy and procedure documents relevant to the patient's care as well as relevant professional standards documents will be subpoenaed. Those documents will then be used for comparison purposes against the patient's records, including observation records, to determine if the care actually delivered to the patient was in accord with the policy and standards documents of the health service. Any omission, without a reasonable explanation, will be relied

upon by the plaintiff's lawyers as evidence of an inadequate standard of care and therefore a breach of the duty of care owed to the patient.

Questioning a medical practitioner's orders

There should be no doubt that a nurse or midwife does have a right and, in most circumstances, a professional and legal obligation to question a medical practitioner's orders, if the nurse or midwife believes the treatment ordered is medically inappropriate or incorrect, or if the nurse or midwife believes the patient has not been adequately informed about the consequences of the particular treatment.

As well, where a nurse or midwife believes that a patient's observations and clinical condition warrant further attention and action by the treating practitioner, he or she should not hesitate to contact him or her and discuss those concerns. This is particularly important in the post-operative phase and in intensive care or emergency situations where close monitoring of the patient is vital and any critical change to the patient's condition manifested by observation and monitoring may well be an indication of problems that require attention. The sooner the problem is identified and acted upon the better. It might be that the treating practitioner may not consider the matters raised by the nurse or midwife to be of any great clinical significance and he or she may choose to ignore the concerns expressed, but it is far better to err on the side of caution when considering whether to contact a patient's treating practitioner about any change to a patient's condition which the nurse or midwife believes is relevant. A failure to advise the treating practitioner of critical observations and/or changes to the patient's condition may well be a direct cause of the patient's condition deteriorating to the point where it is too late to reverse the damage caused. In such circumstances the nurse or midwife may be deemed to be negligent or to have contributed to the damage caused to the patient.

There have been cases where the courts, in one form or another, have been critical of the failure of nurses to express their views on appropriate patient management. One example of such a situation was a Coroner's Court inquiry in South Australia in 1989.[64]

EXAMPLE: CORONER'S INQUEST INTO THE DEATH OF TIMOTHY JOHN BICE

The deceased was a 21-month-old boy who died in a private hospital in South Australia from circulatory collapse due to dehydration caused by gastroenteritis.

The child was taken to the medical centre of the hospital early on the Wednesday afternoon with diarrhoea, vomiting and general lethargy and was seen by Dr H, who advised the mother that the child was suffering from gastroenteritis and was slightly dehydrated.

The mother was advised to administer regular oral fluids and Panadol for the high temperature and told to bring the child back if she continued to be concerned. The child seemed to improve during the day but suffered a large bout of diarrhoea at about 6.00 pm and was finally taken back to the hospital by his mother at about 9.30 pm. He was seen by another doctor who noted that he was somewhat dehydrated and also had an inflamed throat. The doctor decided to admit the child for review by the paediatrician on admission. The paediatrician, Dr B, saw the child

that evening, made a diagnosis of viral gastroenteritis and ordered regular oral foods and observation by the nursing staff.

During Thursday the child suffered frequent bouts of diarrhoea and, after 6.00 pm on the Thursday, frequent vomiting episodes. On the Thursday evening the child became very thirsty, consumed large quantities of fluid, but continued to vomit and was given Maxolon orally at 9.30 pm and, later, another dose intravenously to attempt to alleviate the vomiting. Dr B saw the child at about 10.00 to 10.30 pm but did not examine the child physically at this stage because he testified that he had done so earlier. He testified that there was evidence of dehydration at this stage and that he considered an intravenous drip.

Between 11.00 pm to 2.00 am the condition of the child appeared to stabilise and, when reviewed by Dr B at 2.00 am, he determined that stabilisation had occurred because the child had ceased to vomit. However, at 4.00 am and 5.15 am changes were noted in the child's pulse and respiratory rates which were not reported to the doctor. Between 5.40 and 5.45 am the child had a cardiac arrest. The doctor was notified on two occasions of this event and stated twice that he could not attend. However, he reversed this decision and arrived at the hospital at 6.45 am by which time the child had died.

In handing down his findings the coroner was quite critical, amongst other issues, of the failure of the nursing staff to communicate adequately with the paediatrician, Dr B, about their concern for the child's condition on the Thursday evening. He expressed that criticism in the following terms:

> The evidence establishes to my satisfaction that at various times the nursing personnel were concerned with T's condition. An approach was made to the then Director of Nursing, the Witness Sister A. She deposed to this in evidence and as a result apparently sought an interview with the Chief Executive Officer of the Hospital … It is perhaps unfortunate, although understandable, in some respects, that not one of the staff expressed their concern directly to Dr B and I also gathered the distinct impression that most, if not all, of the nursing staff nurtured the hope that intravenous therapy would be commenced some time during the Thursday evening. This appears to me to be a reasonable inference from the evidence given by the staff concerned. One staff member no doubt did approach Dr B. I accept the reluctance of staff members to approach a medical practitioner expressing his/her concern about a patient, but there are times when this protocol should be set aside. It is no doubt true that some practitioners may well resent being approached by a trained sister [sic] in such circumstances … There is no evidence to suggest that Dr B falls in this category. Nevertheless, I consider the trained nursing sisters have the requisite experience to express an opinion concerning a particular patient's condition.[65]

The coroner in this matter went on to recommend that, as a matter of practice, the nursing staff should communicate their concerns directly with the doctor in future. He expressed that recommendation as follows:

> There is no doubt on the evidence of Dr D (an expert witness) that he strongly supports the view that experienced nursing staff should have no compunction or hesitation in approaching a medical practitioner in charge of the case if they (the staff) are or become concerned about the child's condition.[66]

And later:

> It is quite clear from the evidence, particularly of Dr D, that trained nursing staff employed at the Adelaide Children's Hospital are encouraged to approach a medical person if they have a concern about a particular patient's condition. This is a commonsense approach to the situation and can really only have beneficial results. I am confident that most, if not all, medical practitioners would not oppose this practice by trained nursing staff in hospitals generally.[67]

OTHER EXAMPLES

Two Canadian cases are also of interest on this point. In one, nurses were found not negligent in failing to further contact the treating practitioner with their concerns about the condition of a patient's leg.[68] The patient subsequently required an amputation of his foot. In delivering his judgment on appeal, the judge said that the reason why the nurses were *not* negligent was that he accepted the evidence of the treating medical practitioner that he would have taken no notice of the nurses even if they had informed him again in relation to their concerns about the patient.

In similar circumstances in another case, the nurses were held to be negligent for not calling the doctors, again despite the fact that the nurses had been expressing and documenting their concerns for 3 days.[69] The reason why they *were* held to be negligent on this occasion, was because the doctors gave evidence to the fact that, if they had been informed of the patient's most recent deterioration, they would have acted.

Comment

The lesson to be learned from the experiences of all of the cases is that, on balance and if in any doubt, the nurse or midwife should take steps to notify the treating medical practitioner and express his or her concerns and at the same time make a written entry in the patient's record of the action taken.

What has to be addressed is the most appropriate and sensible way for a nurse or midwife to deal with such matters, given the possibility that such a situation may get out of hand. In the first instance, as a matter of courtesy and commonsense, the nurse or midwife should discuss her or his concerns directly and discreetly with the medical practitioner involved. Whether such an approach would influence the practitioner to alter the proposed course of treatment would depend very much on the facts and circumstances, but nevertheless a nurse or midwife is clearly entitled to raise his or her professional concerns. Indeed, in any situation where a nurse or midwife is involved with a medical practitioner in patient or client care, a nurse or midwife is not only entitled to discuss the appropriateness or otherwise of the treatment proposed but is also professionally and legally obligated to do so.

For example, if a medical practitioner prescribed a schedule of medications that a nurse or midwife knew or ought to have known or believed to be excessive or dangerous to the patient's wellbeing, then the standard of care expected of the professionally competent nurse or midwife would be that he or she express the concerns to the treating doctor. Further, if the practitioner disagreed or refused to alter the medication order following those discussions, and if the nurse or midwife still believed that the particular course of medication proposed was incorrect or inappropriate, then the nurse or midwife would be entitled and, depending on the circumstances, obliged to express the concerns formally to the appropriate authorities. Equally, the nurse or midwife may refuse to administer the medication, as long as he or she does so on reasonable grounds.

The mechanisms by which a nurse or midwife would formalise his or her concerns would vary depending on the circumstances. In a hospital or nursing home, it would be done using the administrative channels available. Outside of a hospital or nursing home, it may be necessary to raise such concerns with the relevant state or territory health authority or medical registration board. If a nurse or midwife formally raises a complaint concerning the professional competence of a medical practitioner (or any fellow healthcare professional for that matter) the complaint should always be in writing, setting out objectively the details of the complaint and the reasons in support of it. The particular problem that arises in relation to complaints of professional competence is also relevant in any consideration of the law relating to defamation.

Negligence: Principle 2 — that the defendant's conduct on the occasion in question fell below the standard of care expected

If what the defendant did or failed to do fell below the standard of care expected, the defendant is in breach of his or her duty of care to the plaintiff. Although this principle may appear to be encompassed within a somewhat long-winded statement, it follows automatically once the existence of a duty of care and the expected standard of that care have been established in accordance with the civil standard of proof. Having reached this stage, the plaintiff has established on the balance of probabilities:

- that a duty of care exists;
- the standard of care expected as part of that duty;
- that the defendant failed to achieve the standard of care expected in the circumstances under review.

If that is so, then:

- the defendant is in breach of his or her duty of care to the plaintiff.

The plaintiff must then proceed to establish the next principle.

Negligence: Principle 3 — that, as a consequence of the defendant's breach of his or her duty of care to the plaintiff, the plaintiff suffered damage

Two factors need to be established:

1) that the plaintiff suffered damage — if the plaintiff suffered no damage, no compensation can be awarded; and

2) the damage being complained about is a consequence of the defendant's negligent act; that is, there must be a direct or causal relationship between the damage and the negligent act.

Both issues require careful consideration.

DAMAGE SUFFERED BY THE PLAINTIFF

It has already been stated that it is necessary to establish all the principles in a negligence action in order to succeed. Therefore, the absence of any damage to the plaintiff, even in the presence of a clear breach of the duty of care, will preclude any action from being commenced. In normal circumstances, the administration of a wrong medication to a patient constitutes a clear breach of the duty of care a nurse or midwife owes to that patient; the reason being that, as a generally accepted professional standard, a registered nurse or midwife is not expected to make medication errors. For example, assume that a nurse had been directed to put glycerine and acid carbol drops into a patient's left ear before he was sent home. Assume that the nurse got the correct drops, but instead of putting them in the patient's left ear as instructed she misunderstood and put them into the patient's right ear. What the nurse did is obviously in breach of her duty of care to the patient. However, it is highly unlikely that the nature of the drops she put in the wrong ear was such as to cause any physical damage to the patient's right ear. Obviously, if they did, it would be a different matter, but for the purposes of this explanation it is safe to presume they did not.

There are obviously other examples where, because of what the nurse does or fails to do, he or she would be in breach of his or her duty of care to a patient, but the patient suffers no damage. If there is no damage there can be no action, because it is for the damage caused that the plaintiff is compensated in a negligence action.

Damage (or harm) in the context of negligence refers to three particular types of damage which the courts will recognise and, if proved on the balance of probabilities to exist, will compensate for.

The civil liability legislation of the states and territories refer to 'harm' or 'injury' and, relevantly, define both. For example, section 5 of the *Civil Liability Act 2002* (NSW) defines 'harm' as follows:

> ***harm*** means harm of any kind, including the following:
> a) personal injury or death,
> b) damage to property,
> c) economic loss.

And defines 'personal injury' as follows:

> ***personal injury*** includes:
> a) pre-natal injury, and
> b) impairment of a person's physical or mental condition, and
> c) disease.

In relation to 'mental harm', further definitions are provided. Section 27 of the *Civil Liability Act 2002* (NSW) provides the following definitions:

> ***consequential mental harm*** means mental harm that is a consequence of a personal injury of any other kind.
>
> ***mental harm*** means impairment of a person's mental condition.
>
> …
>
> ***pure mental harm*** means mental harm other than consequential mental harm.

All of the other states and territories have adopted similar definitions except that the Northern Territory and Queensland do not define 'mental harm'. In relation to the definitions provided relevant to 'harm' or 'injury' see: *Civil Law (Wrongs) Act 2002* (ACT) ss 32 and 40; *Personal Injury (Liabilities and Damages) Act 2003* (NT) s 3; *Civil Liability Act 2003* (Qld) Sch 2 (Dictionary); *Civil Liability Act 1936* (SA) s 3; *Civil Liability Act 2002* (Tas) ss 3 and 29; *Wrongs Act 1958* (Vic) ss 28B and 67; *Civil Liability Act 2002* (WA) ss 3 and 5Q.

Mental harm

Mental harm has traditionally been referred to as nervous shock and is an area of harm that has become increasingly recognised by the courts. In keeping with developments in this area of medicine, the existence of permanent psychiatric harm which can be medically established is now acknowledged by the courts as a form of harm entitling the plaintiff to compensation.

It would be fair to say that up until the Ipp Report and the recommendations in relation to civil liability law, the High Court had taken an increasingly liberal view towards claims at common law for psychiatric injury arising from a defendant's negligent act. While maintaining that the psychiatric injury claimed had to be a genuine psychiatric illness and not simply psychological distress, grief or anger, the High Court emphasised that the main factor justifying recovery for mental harm in the form of psychiatric injury was reasonable foreseeability.

The recommendations of the Ipp Committee included a winding back of the High Court decisions in relation to mental harm by advocating a return to what is known as the 'normal fortitude' rule. As a consequence, all states and territories except the Northern Territory and Queensland have legislated to do so.

In addition to the definition of mental harm and associated terms, section 32 of the *Civil Liability Act 2002* (NSW) provides that the duty of care owed in relation to mental harm is as follows:

> 1) A person (***the defendant***) does not owe a duty of care to another person (***the plaintiff***) to take care not to cause the plaintiff mental harm unless the defendant ought to have foreseen that a person of normal fortitude might, in the circumstances of the case, suffer a recognised psychiatric illness if reasonable care were not taken.
> 2) For the purposes of the application of this section in respect of pure mental harm, the circumstances of the case include the following:
>
> a) whether or not the mental harm was suffered as the result of a sudden shock,

b) whether the plaintiff witnessed, at the scene, a person being killed, injured or put in peril,
c) the nature of the relationship between the plaintiff and any person killed, injured or put in peril,
d) whether or not there was a pre-existing relationship between the plaintiff and the defendant.

3) For the purposes of the application of this section in respect of consequential mental harm, the circumstances of the case include the personal injury suffered by the plaintiff.

4) This section does not require the court to disregard what the defendant knew or ought to have known about the fortitude of the plaintiff.

For similar provisions in the other states and territories, see: *Civil Law (Wrongs) Act 2002* (ACT) s 34; *Civil Liability Act 1936* (SA) s 53; *Civil Liability Act 2002* (Tas) s 34; *Wrongs Act 1958* (Vic) s 72; *Civil Liability Act 2002* (WA) ss 5S and 5T. The Northern Territory and Queensland do not define 'mental harm'.

As well, in New South Wales, Tasmania and Victoria, limitations are placed on the recovery of compensation for pure mental harm, as section 30 of the *Civil Liability Act 2002* (NSW) provides in the following terms:

1) This section applies to the liability of a person (***the defendant***) for pure mental harm to a person (***the plaintiff***) arising wholly or partly from mental or nervous shock in connection with another person (***the victim***) being killed, injured or put in peril by the act or omission of the defendant.

2) The plaintiff is not entitled to recover damages for pure mental harm unless:
a) the plaintiff witnessed, at the scene, the victim being killed, injured or put in peril, or
b) the plaintiff is a close member of the family of the victim.

3) Any damages to be awarded to the plaintiff for pure mental harm are to be reduced in the same proportion as any reduction in the damages that may be recovered from the defendant by or through the victim on the basis of the contributory negligence of the victim.

4) No damages are to be awarded to the plaintiff for pure mental harm if the recovery of damages from the defendant by or through the victim in respect of the act or omission would be prevented by any provision of this Act or any other written or unwritten law.

…

The same section also defines 'close member of the family' and 'spouse or partner' in relatively confined terms.

For similar provisions in Tasmania and Victoria, see: *Civil Liability Act 2002* (Tas) s 32; *Wrongs Act 1958* (Vic) s 73.

The legislative changes made in most of the states and territories make it harder for persons to succeed in being compensated for pure mental harm.

THE CAUSAL RELATIONSHIP BETWEEN THE DAMAGE AND THE NEGLIGENT ACT

Establishment of this principle requires that there be a direct or causal relationship between the defendant's breach of his or her duty of care and the plaintiff's damage. This is often referred to as the *principle of causation*. The breach of the duty of care must cause the damage, otherwise no compensation will be awarded.

Provision is made in the civil liability legislation of the states and territories arising from the Ipp Report as to the scope and application of this principle in determining liability. For example, section 5D of the *Civil Liability Act 2002* (NSW) provides:

1) A determination that negligence caused particular harm comprises the following elements:
   a) that the negligence was a necessary condition of the occurrence of the harm (***factual causation***), and
   b) that it is appropriate for the scope of the negligent person's liability to extend to the harm so caused (***scope of liability***).
2) In determining in an exceptional case, in accordance with established principles, whether negligence that cannot be established as a necessary condition of the occurrence of harm should be accepted as establishing factual causation, the court is to consider (amongst other relevant things) whether or not and why responsibility for the harm should be imposed on the negligent party.
3) If it is relevant to the determination of factual causation to determine what the person who suffered harm would have done if the negligent person had not been negligent:
   a) the matter is to be determined subjectively in the light of all relevant circumstances, subject to paragraph (b), and
   b) any statement made by the person after suffering the harm about what he or she would have done is inadmissible except to the extent (if any) that the statement is against his or her interest.
4) For the purpose of determining the scope of liability, the court is to consider (amongst other relevant things) whether or not and why responsibility for the harm should be imposed on the negligent party.

For similar provisions in the other states and territories see: *Civil Law (Wrongs) Act 2002* (ACT) s 45; *Civil Liability Act 2003* (Qld) s 11; *Civil Liability Act 1936* (SA) s 34; *Civil Liability Act 2002* (Tas) s 13; *Wrongs Act 1958* (Vic) s 51; *Civil Liability Act 2002* (WA) s 5C.

There is no similar provision in the Northern Territory.

At the outset, readers are advised to refer to the facts and decisions of two cases discussed in this chapter for further judicial comment on the issue of causation: *Rogers v Whitaker* (1992) and *Chappel v Hart* (1998).[70] While both cases turned predominantly on the issue of a failure by the treating doctor to warn of risks involved in a particular procedure being a breach of the doctor's duty of care, the question of causation was also extremely important to the ultimate outcome. Given that the doctor was in breach of his duty of care by failing to warn of inherent risks

in the treatment being proposed, did that cause the damage the patient ultimately complained of? In both cases the High Court answered in the affirmative. In doing so, the judges found that both patients relied on the advice given by the particular doctor in deciding to go ahead with the surgery being suggested. In both cases the court found that the respective doctors had failed to give proper advice and warning to their patients about likely complications from the proposed surgery. The court was satisfied that, if the patients had known, they would not have had the surgery. Accordingly, in both cases, a reliance on the respective surgeons' advice in deciding to undergo the surgery was a direct physical cause of the damage which subsequently occurred. In Mrs Whitaker's case she became totally and permanently blind, and in Mrs Hart's case she suffered permanent damage to her vocal cords. As McHugh J said in *Chappel v Hart*:

> Before the defendant will be held responsible for the plaintiff's injury, the plaintiff must prove that the defendant's conduct materially contributed to the plaintiff suffering that injury … it would seem logical to hold a person causally liable for a wrongful act or omission only when it increases … the risk or injury to another person. If a wrongful act or omission results in an increased risk of injury to the plaintiff and that risk eventuates, the defendant's conduct has materially contributed to the injury that the plaintiff suffers whether or not other factors also contributed to that injury occurring.[71]

The common-law principle of causation in negligence is often referred to as the 'but for' test. That is, 'but for' the breach of the duty of care alleged, the plaintiff would not have suffered the damage complained of. That is what is referred to in section 5D(1)(a) of the *Civil Liability Act 2002* (NSW) (and its equivalent provision in the other states and territories) as 'that the negligence was a necessary condition of the occurrence of the harm', or to express it another way 'but for' the breach of the duty of care the harm would not have occurred.

This principle of causation generally is best illustrated by examining the facts of a number of matters that have come before the courts both here and in the United Kingdom. The first is the English case known as *Barnett v Chelsea and Kensington Hospital*.[72] The relevant facts are set out below.

BARNETT V CHELSEA AND KENSINGTON HOSPITAL

Mr Barnett went to the casualty department of a hospital complaining of nausea and vomiting following the drinking of tea some hours before. The nurse in casualty notified the doctor on duty who was also not feeling well and not overly inclined to want to see patients. He advised the nurse to send Mr Barnett home with instructions to go to bed and see his own doctor later in the day. Mr Barnett left the hospital but his condition worsened and some few hours afterwards he died from what was later discovered to be arsenic poisoning. Mr Barnett's widow brought an action against the hospital and the doctor alleging negligence on the part of both.

The decision of the court stated that the hospital had a general duty of care to all the users of its service to provide a safe and competent service, with safe, competent employees. The standard expected of that duty of care would be that people

who present to casualty should have a proper history taken and be examined. The court stated that this had not been done and accordingly the hospital was liable for allowing such an unsafe situation to occur through the actions of its employees. It was also stated that the doctor was in breach of his duty of care to the patient because he failed to examine the patient — which is what the ordinary, reasonable doctor in his position would have done in such circumstances.

In this example:

- the duty clearly existed;
- the standard was well-established;
- the breach was obvious;
- the damage was self-evident (Mr Barnett's death).

However, Mrs Barnett failed in her action because she could not establish that the breach of the duty of care had caused her husband's death. It was established on the evidence that, even if Mr Barnett had been properly examined and a history taken, and if he had been admitted at the time he came to the casualty department, he would still have died. Expert evidence supported the view that the likelihood of the doctor in casualty diagnosing Mr Barnett's illness as arsenic poisoning was highly improbable. This evidence was supported by the fact that of the nearly 4 million people who were admitted to the thousands of hospitals in the United Kingdom each year, fewer than 60 had arsenic poisoning. Thus, the ordinary, reasonable doctor could hardly be expected to diagnose arsenic poisoning in the circumstances being considered. Remember that Mr Barnett was not able to state that he had taken arsenic because he did not know that fact — he could only recount that he had been drinking tea. In addition, expert medical witnesses stated that it would have taken some hours after admission for sufficient investigations to have been completed to permit the correct diagnosis to be made. By then any treatment would have had no effect.

The outcome of that evidence, which was accepted by the court, was that even though the hospital and the doctor were in breach of their duty of care to Mr Barnett and even though the damage was clear, Mrs Barnett could not succeed, because the arsenic, and not the breach of the duty of care, had caused Mr Barnett's death.

Comment

A hypothetical example of such an outcome might well be as follows. A midwife who is administering medications in a postnatal ward gives the wrong patient 500 mg of ampicillin. Some 20 minutes or so after taking the antibiotic the patient has a massive postpartum haemorrhage and almost dies. Eventually, over the next couple of months, the patient makes a gradual recovery from all of the attendant medical problems that acute and sudden blood loss can cause. Knowing that she had been given the ampicillin in error, consideration is given to bringing a claim in negligence alleging that the administration of the ampicillin was the cause of her sudden and precipitate postpartum haemorrhage. Clearly the midwife was in breach of his or her duty of care to the patient by administering a medication not meant

for that patient. Using the 'but for' test the argument would have to be 'but for' the midwife's administering the wrong medication, the postpartum haemorrhage would not have occurred. It would be most improbable, in our view, that giving 500 mg of ampicillin to the patient 20 minutes before had caused her postpartum haemorrhage. Alternatively, if by calling expert medical evidence the patient could establish, on the balance of probabilities, a causal relationship between the two events, then the patient would be entitled to rely on the medication error as the basis for a claim in negligence.

A more recent and interesting example of the importance of causation is to be found in a case which was decided in England in 1985. The case is *Hotson v Fitzgerald*.[73] The relevant facts are set out below.

HOTSON V FITZGERALD

In 1977, when Stephen Hotson was 13 years old, he had an accident at school. He fell some 4 metres to the ground from a rope on which he had been swinging, landing heavily on his buttocks. He suffered an acute traumatic fracture separation of the left femoral epiphysis. He was taken to St Luke's Hospital at Maidenhead where his left knee was X-rayed and showed no injury. He was sent home with a tubigrip elastic knee bandage and told to return in 10 days if necessary. He went home and continued to suffer great pain. His father took him to his local general practitioner who simply prescribed tablets. After 5 days at home and still with no relief from his pain, he was taken back to St Luke's Hospital and this time they X-rayed his hip. The fracture was detected and was treated by surgical reduction and fixation with three pins.

As a result of the injury to his femoral epiphysis at that age, Stephen Hotson suffered avascular necrosis with resultant distortion and collapse of the epiphysis. This, in turn, produced increasing deformity of the left hip, shortening of the left leg and obvious wasting and marked weakness of the whole leg. Opinion was that osteoarthritis was inevitable. Mr Hotson brought an action in negligence against the partnership of general practitioners which he had attended after his initial discharge from St Luke's Hospital and against the East Berkshire Health Authority as the employing authority for St Luke's Hospital at Maidenhead. He alleged that their failure to diagnose his injury immediately following his accident at school had caused the avascular necrosis of the epiphysis to develop, which then led to his resultant permanent disability.

The matter did not come to trial until 1985 and at the beginning of the trial Mr Hotson, by now 21 years old, discontinued the action against the doctors in the general practitioner partnership and the case proceeded against the East Berkshire Health Authority as the employing authority for St Luke's Hospital at Maidenhead.

At the outset of the hearing the Health Authority admitted that there had been a breach of duty by the Health Authority in the conduct of the examination of Mr Hotson on the day of his accident, as a result of which his condition was not correctly diagnosed until 5 days later, for which he then received operative treatment the next day. What the Health Authority would not admit, however, was that the

delay in diagnosis of Mr Hotson's injury caused the damage of which he was now complaining. The barrister for the Health Authority argued that position on two grounds:

1) that the initial injury was so severe that avascular necrosis of the epiphysis was inevitable;
2) that the delay in treatment would not in theory and, as shown by published medical literature, had not in practice been found to increase the risk of avascular necrosis.

Naturally enough, considerable expert medical evidence was presented by the Health Authority in support of their argument based on the above two grounds. Equally expert medical evidence was presented by Mr Hotson's barrister in support of Mr Hotson's case. The judge himself referred to the conflicting medical evidence of the experts, which he had difficulty in accepting.

After considering all of the evidence, particularly on the point of causation, the judge arrived at the following findings of fact:

- Even if the Health Authority had correctly diagnosed and treated Mr Hotson on the day of the injury, there was a high probability, which the judge assessed as a 75 percent risk, that Mr Hotson's injury would have followed the same course as it in fact had; that is, he would have developed avascular necrosis of the whole femoral head with all the same adverse consequences as had already ensued and with all the same adverse future prospects.
- That 75 percent risk of permanent injury that Mr Hotson faced became inevitable by the admitted breach of the duty of care of the Health Authority in the conduct of the examination of Mr Hotson immediately following his injury. Thus, the delay in diagnosis denied Mr Hotson the 25 percent chance that, given immediate treatment, avascular necrosis would not have developed.
- Had avascular necrosis not developed, Mr Hotson would have made very nearly a full recovery.
- The reason why the delay sealed Mr Hotson's fate was because it allowed the pressure caused by haemarthrosis — the bleeding of ruptured blood vessels into the joint — to compress and thus block the intact but distorted remaining vessels. As a result, even if the fall had left intact sufficient vessels to keep the epiphysis alive (the judge found the first point above possible but improbable), such vessels would have become occluded and ineffective for this purpose.

The judge then proceeded to award Mr Hotson 25 percent of the total damages sum determined, based on the above findings of fact. The Health Authority appealed that decision and was unsuccessful.[74]

The courts in Australia have followed the causation principle as enunciated in the above United Kingdom cases. That principle has now been codified in the civil liability legislative provisions referred to above and the following case provides an example of the application of those provisions.

FINCH V ROGERS[75]

This decision of the New South Wales Supreme Court addressed the application of the 'but for' test in the principle of causation and section 5D(1)(a) and (b) of the *Civil Liability Act 2002* (NSW) in particular.

Mr Finch was a musician and music student who was diagnosed with a particularly aggressive form of testicular cancer. Dr Rogers operated to remove the affected testicle. Following surgery there was a delay of some weeks before steps were taken by Dr Rogers to follow up the surgery with post-operative monitoring including blood tests and scans.

When that was done, there was clinical evidence that the cancer had spread to the abdominal lymph glands and as a result Mr Finch had to undergo an extra cycle of chemotherapy. Following the additional cycle of chemotherapy he developed tinnitus, hearing loss and peripheral neuropathy. In bringing his action, Mr Finch argued that Dr Rogers had been negligent in not adequately explaining the need for immediate ongoing post-operative monitoring and undertaking the necessary investigations to determine whether there had been any spread of the tumour. Because of the delay in that process, Mr Finch had been required to have the additional cycle of chemotherapy resulting in the damaging and debilitating side effects that he sustained.

On behalf of Dr Rogers, the breach of the duty of care was admitted, but it was argued that that breach had not caused the damage Mr Finch complained of. Consequently, in order to succeed, Mr Finch had to show there was a causal relationship between the breach of the duty owed to him by Dr Rogers and the damage he sustained. He succeeded in his action and in addressing the issue of causation, and in particular, section 5D(1)(a) and (b) of the *Civil Liability Act 2002* (NSW), of which the judge said:

> The evidence does, to my mind, establish as a probability that the fourth cycle materially contributed to the disabilities from which the plaintiff now suffers. But for the fourth cycle, there may have been damage but it probably would not have been disabling.[76]

And further:

> Addressing the issue of factual causation, but for the breach, and the delay which was the consequence of the breach, the following can be said: First, that Mr Finch would probably have been given Indiana BEP chemotherapy on Monday 30 December 1996 or, at the latest, Monday 6 January 1997. Second, that on either day, he would have been regarded as a good prognosis patient. Third, that given his response to chemotherapy (which was good), he would have needed three cycles, not four. Fourth, that he would not have suffered the disabling consequences of ototoxicity and neurotoxicity which were evident after the fourth cycle.
>
> In short, I consider that the defendant's negligence was a necessary condition of the harm that ensued (s 5D(1)(a)). I further believe that it is appropriate that the scope of the defendant's liability extends to the harm so caused

(s 5D(1)(b)). The consequences were, in each case, a foreseeable result of the breach.[77]

TABET V GETT[78]

This decision of the High Court of Australia addresses the issue of causation based on a 'loss of chance' in relation to medical treatment. It emphasises the point that, for a plaintiff to succeed in an action alleging negligence, he or she must establish each element of the claim in accordance with the requisite standard in civil cases, that being on the balance of probabilities.

Reema Tabet, a 6-year-old girl, was admitted to hospital on 11 January 1991. She had recently suffered from chicken pox which had resolved but both before and after that illness she suffered headaches, nausea and vomiting. She was under the care of Dr Gett, who made a provisional diagnosis of chicken pox, varicella meningitis or encephalitis.

On 14 January 1991, the young child had a seizure. As a consequence a CT scan was undertaken. It disclosed a brain tumour that had apparently been present for the better part of 2 years. The tumour was surgically removed but by that time the child had sustained irreversible brain damage because of the raised intracranial pressure from the build up of cerebrospinal fluid.

On behalf of the child an action was commenced alleging Dr Gett had been negligent in failing to order a CT scan on 11 January or 13 January at the latest. The latter date was identified because on that date the nursing staff observed that the young child's pupils were unequal and her right pupil was non-reactive.

In the evidence before the judge who heard the case in the first instance it could not be established on the balance of probabilities that the taking of a CT scan and the administration of steroids or the insertion of a drain earlier than was done would have averted the child's brain damage. Notwithstanding that, the judge determined that 'but for' the delay in diagnosis and treatment by not undertaking the CT scan and associated treatment on 13 January rather than on 14 January after the child's seizure, the child would have had a 40 percent 'chance' of a better outcome and awarded her compensation.

Dr Gett appealed the decision to the New South Wales Court of Appeal to have the decision overturned and was successful. On behalf of the young girl, an appeal was lodged with the High Court. That appeal was unsuccessful and in dismissing the appeal Kiefel J said:

> The appellant is unable to prove that it was probable that, had treatment by corticosteroids been undertaken earlier, the brain damage that occurred on 14 January 1991 would have been avoided. The evidence was insufficient to be persuasive. The requirement of causation is not overcome by redefining the mere possibility, that such damage as did occur might not eventuate, as a chance and then that it is lost when the damage actually occurs. Such a claim could only succeed if the standard of proof were lowered, which would require a fundamental change to the law of negligence. The appellant suffered dreadful injury, but the circumstances of this case do not provide

> a strong ground for considering such change. It would involve holding the respondent liable for damage which he most certainly did not cause.[79]

On the need for causation to be established on the balance of probabilities the judge also said:

> The common law requires proof, by the person seeking compensation, that the negligent act or omission caused the loss or injury constituting the damage. All that is necessary is that, according to the course of common experience, the more probable inference appearing from the evidence is that a defendant's negligence caused the injury or harm. 'More probable' means no more than that, upon a balance of probabilities, such an inference might reasonably be considered to have some greater degree of likelihood; it does not require certainty.[80]

It should be noted that the *Civil Liability Act 2002* (NSW) was not relevant to the outcome in this case as the events grounding the action had occurred prior to that Act being passed.

Negligence: Principle 4 — the damage that the plaintiff is complaining about is a reasonably foreseeable consequence of the defendant's negligent act

The general proposition here is that the defendant should have to compensate the plaintiff only for such damage that can be said to be a reasonably foreseeable consequence of the defendant's negligence. There are some types of damage that the law will acknowledge the defendant should not have to pay for, because the damage is too remote a consequence of the defendant's negligent act; that is, it was not reasonably foreseeable.

The way this principle was approached by the courts is best illustrated by reference to two decisions of the Privy Council in the 1960s. These dealt with an appeal from two matters that originated in Sydney arising from the same facts. At the time, the Privy Council was the final and superior court of appeal for Australian courts. The principle that the decisions finally determined was clearly binding on all Australian courts. The decisions are reported in the English law reports as: *Overseas Tankship (UK) v Morts Dock & Engineering Co* (1961) and *Overseas Tankship (UK) v Miller Steamship Co* (1967).[81] The relevant facts are set out below.

A vessel called the *Wagon Mound* was bunkering for oil at the Caltex Wharf in Sydney Harbour. While doing so, the workers employed on the vessel negligently spilled a quantity of oil into the harbour. The oil slick that formed eventually floated over to the Mort's Dock area of the harbour, where other vessels were moored while undergoing repairs, which included oxyacetylene welding. Inquiries were made about the possible dangers of the oil in such an area, but because of the apparently high flashpoint of furnace oil it was not considered a fire hazard. But the oil did catch fire, apparently caused by molten metal from the oxywelding dropping into the water and igniting some floating waste material. The docks and the ships moored at the docks were extensively damaged by fire. The owners of the dock brought an

action against the owners of the *Wagon Mound* at the time, alleging negligence. The action failed because the judge in the first instance found that, on the evidence, the defendants did not know, and could not reasonably be expected to know, that furnace oil was capable of igniting in the particular circumstances that it did. The judge's finding was upheld in the appeal to the Privy Council.

The principle enunciated here was not only that damage had to be foreseeable but the 'particular type' of damage which the plaintiff was complaining about had to be foreseeable. In this example, the court was saying that although damage from the oil fouling the dock area was foreseeable, damage by fire was totally different in kind and accordingly the court dismissed the claim.

Following that decision, the courts were required to examine the principle again when the owner of one of the ships moored at the docks at the time of the fire also brought an action against the owners of the *Wagon Mound*, alleging negligence. In the second decision relating to the same incident, the appeal court widened the notion of foreseeability of damage by saying that damage was foreseeable if it was damage that a reasonable person, placed in the defendant's position, would consider had a 'real risk' of occurring. As the officers of the *Wagon Mound* had acknowledged that furnace oil was very difficult, but not impossible, to ignite, there was therefore a 'real risk' that it would ignite. Accordingly, on this occasion the owners of the *Wagon Mound* were found liable on the basis that the damage could be said to be a foreseeable consequence of spilling the oil in the first instance, or failing to do anything about it in the second instance.

In the second decision involving the *Wagon Mound* the court dismissed the argument that a remote risk was not reasonably foreseeable in the following terms:

> If a real risk is one which would occur to the mind of a reasonable man in the position of the defendant's servant and which he would not brush aside as far-fetched, and if the criterion is to be what that reasonable man would have done in the circumstances, then surely he would not neglect such a risk if action to eliminate it presented no difficulty, involved no disadvantage and required no expense.[82]

The above principles were adopted by Australian courts but they have been criticised as being too expansive in their interpretation. The issue was raised in the Ipp Report in the following terms: 'should the defendant be held liable for any of the harmful consequences of the negligence, and if so, for which'. The report concluded that there was a need to further consider the scope of a defendant's liability for damage arising from the defendant's negligent act.

In an attempt to place some limitation on liability in negligence and therefore liability for damages arising within the context of foreseeability of harm, the civil liability legislation made provision for the principles that a court must consider in determining causation and what had earlier been referred to as the principle of remoteness but is now characterised as the 'scope of liability' for the defendant's negligent act. The relevant legislative provisions are those referred to above in discussing the principle of causation and remoteness. That is, section 5D of the *Civil Liability Act 2002* (NSW) and the equivalent provisions of the other states and territories identified (with the exception of the Northern Territory).

In a number of respects, the principles do no more than restate the common-law principles arising from the *Wagon Mound* decisions but with the limitation of probability of harm occurring.

Damages

Once the plaintiff has established, according to the civil standard, all of the principles required to support the claim of negligence, it is then necessary for the court to determine the amount of financial compensation (damages) to be awarded to the plaintiff.

As a general rule, the common law made provision for ordinary compensatory damages that were classified as specific damages and general damages.

Specific damages are those which can be specifically quantified in monetary amounts. For example, compensation claimed for 2 months' loss of salary can be precisely calculated or medical expenses can be accurately stated.

Very often, one of the largest components of specific damages as part of ordinary compensatory damages is the amount claimed for future economic loss as a result of the loss of the plaintiff's earning capacity arising from the defendant's negligence. As well, the economic cost of providing attendant care needs to the plaintiff on an ongoing basis can be significant, particularly if the plaintiff is young, severely injured with quadriplegia, or brain damaged, and will require care for the rest of his or her life.

General damages are those which, as described, are general in nature and are amounts awarded for 'pain and suffering' and 'loss of enjoyment of life'. One of the factors driving the legislative changes made to civil liability law arising from the Ipp Report was the widely held belief that the amounts awarded by the courts as compensation for such losses were excessive and driving up insurance costs.

As a consequence, there are now significant legislative constraints limiting the amounts that may be awarded as compensation both for specific damages based on economic loss and general damages based on non-economic loss. These legislative constraints apply in all states and territories.

Using the *Civil Liability Act 2002* (NSW) as an example, there is now a threshold test to be met for entitlement to, and a cap on the amount that may be awarded for, non-economic loss. In the first instance, no amount of compensation can be awarded for non-economic loss 'unless the severity of the non-economic loss is at least 15% of a most extreme kind'. Even if a plaintiff is able to establish that threshold requirement, there is a cap on the maximum that may be awarded even in the most extreme cases.

There is also a cap placed on the damages a court may award for future economic loss based on a plaintiff's earning capacity. Where a plaintiff is awarded a calculated lump sum for future economic loss, it is now to be discounted by 5 percent, or a rate otherwise prescribed. Further, there is now a limit that may be recovered for what is termed 'gratuitous attendant care services'. Such services are the care services that a family member, for example a mother or father, wife or husband, will need to provide in order to ensure continuing care for the plaintiff, generally in the family home.

At common law, as a component of financial loss, courts may award what is known as aggravated, exemplary or punitive damages. This is an amount of money awarded to the plaintiff in addition to any other compensatory amounts that may be awarded. Such damages are rarely awarded and are generally awarded as a mark of disapproval by the court of the defendant's outrageous conduct towards the plaintiff.

While there is provision within the ambit of compensatory damages for a court to award a plaintiff aggravated, exemplary or punitive damages, such damages have now been completely or partially abolished in relation to personal injury claims.

There is now a prohibition or significant limitation on such damages in the new civil liability legislation.

For example, in New South Wales a court cannot award aggravated, exemplary or punitive damages in personal injury claims where the act or omission relied upon was the defendant's negligence. In Queensland a court can only award aggravated, exemplary or punitive damages in a personal injury claim where the personal injury arose from an unlawful, intentional act or an unlawful sexual assault or other sexual misconduct.

Overall, the legislative changes made impacting on the limits that may be awarded in compensatory damages, as well as the threshold tests that have to be met by a plaintiff to qualify for damages, have made it very difficult for a plaintiff and have significantly reduced the amounts able to be awarded by the courts. Such changes will, we believe, have harsh consequences for many plaintiffs. It remains to be seen if governments are ultimately persuaded to amend some of the more restrictive provisions at some future time.

There are three important factors to bear in mind when considering the question of damages generally.

1) In the absence of establishing negligence no damages can be awarded.
   Obviously the exercise the plaintiff has to undertake in order to qualify for an award of damages requires the plaintiff to find that somebody was negligent; that is, that somebody other than the plaintiff was at fault in what was done or failed to be done. There are situations where the plaintiff is unable to do that and is therefore unable to bring a negligence action against anybody. For example, a man driving a motor vehicle along a highway comes to a bend in the road. In negotiating that bend he drives too fast, the car goes out of control, runs off the highway and hits a tree. The driver suffers serious injuries, including paraplegia. In this situation, the driver of the motor vehicle would not be able to bring an action in negligence against anyone because he would not be able to find fault with anyone — apart from himself perhaps, and he cannot sue himself. At best he would become entitled to an invalid pension. The outcome would be different, however, if instead of running off the road out of control, the driver of the car sustained his injuries when the driver of another vehicle failed to give way at an intersection. In that type of accident the injured driver would be able to find somebody who was at fault; that is, the driver of the other motor vehicle or, more importantly, his or her insurance

company, who would be liable to pay the amount of compensation awarded if negligence is established.

2) If the plaintiff should succeed in proving negligence, he or she must also ensure that the person or party made liable has adequate financial resources to pay the amount awarded, either directly or by access to an insurance policy. The task of the courts is not to provide the money awarded to the plaintiff, but rather to assess and state the amount of damages the plaintiff is entitled to once negligence has been established or admitted. The plaintiff must then recover that amount from the defendant or the defendant's insurer.
3) Common-law principles have long determined that, if a person dies as the result of the negligent act of another, the person's right to bring an action in negligence 'dies' with them.

Clearly, such a principle had harsh consequences when a person died leaving behind a family who had been financially dependent on that person's income and could have reasonably looked forward to that income for many years to come. To overcome the harshness of that common-law principle, parliaments have intervened and passed legislation which permits the relatives of a person killed in such circumstances to bring an action claiming compensation for the loss of income they could foreseeably have been able to rely on. In New South Wales the legislation referred to is known as the *Compensation to Relatives Act 1897*, but in the other states and territories it has somewhat different titles.[83]

Generally speaking, the category of relatives who can bring such an action is clearly defined in the Act. For example, the New South Wales Parliament passed the *Compensation to Relatives (De Facto Relationships) Amendment Act 1984* which provided for the inclusion of a de facto spouse as a relative.

Provision for an apology within the context of potential civil liability for negligence

Very often, persons who commence negligence litigation against healthcare professionals are reported as often being motivated by the failure or refusal of said professionals and health authorities to tell them the 'how and why' when things go wrong and never receiving an expression of regret or apology for the negligent actions.

The main reason given by health authorities and medical practitioners for not admitting errors and apologising is because such statements are seen as an admission of liability with financial and insurance implications.

This phenomena has been acknowledged in the civil liability legislation enacted following the Ipp Report, although there are differences as to how the issue is dealt with.

For example, in New South Wales section 69 of the *Civil Liability Act 2002* gives protection from liability for an apology in the following terms:

1) An apology made by or on behalf of a person in connection with any matter alleged to have been caused by the person:
   a) does not constitute an express or implied admission of fault or liability by the person in connection with that matter, and

b) is not relevant to the determination of fault or liability in connection with that matter.

2) Evidence of an apology made by or on behalf of a person in connection with any matter alleged to have been caused by the person is not admissible in any civil proceedings as evidence of the fault or liability of the person in connection with that matter.

Section 68 of the Act defines an apology as follows:

> ***apology*** means an expression of sympathy or regret, or of a general sense of benevolence or compassion, in connection with any matter whether or not the apology admits or implies an admission of fault in connection with the matter.

All other states and territories make provision for an 'apology' or an 'expression of regret'. The respective provisions are: *Civil Law (Wrongs) Act 2002* (ACT) ss 12–14; *Personal Injuries (Liabilities and Damages) Act 2003* (NT) ss 12 and 13; *Civil Liability Act 2003* (Qld) s 72; *Civil Liability Act 1936* (SA) s 75; *Civil Liability Act 2002* (Tas) s 7; *Wrongs Act 1958* (Vic) ss 14I and 14J; *Civil Liability Act 2002* (WA) s 5AH.

There is considerable similarity between the respective legislative provisions. For example, with the exception of South Australia, all state that any 'apology' or 'expression of regret' is not admissible in any civil proceedings as evidence of fault or liability. The Northern Territory, Queensland and South Australia use the term 'expression of regret' rather than 'apology' being defined to include 'an expression of regret', as used in the other states and territories. The definition of 'apology' in the Australian Capital Territory is similar to that in New South Wales — both of which would appear to provide that an apology may include an admission of fault. In Victoria and Western Australia an 'apology' is said to mean 'an expression of sorrow, regret or sympathy by a person' that does not contain an acknowledgment of fault by that person. Victoria goes somewhat further than the other states and territories by providing that in addition to an apology not constituting an admission of liability in civil proceedings as evidence of fault, such an apology is also not an admission of 'unprofessional conduct, carelessness, incompetence or unsatisfactory performance'.

The most limited provisions are found in the Northern Territory and South Australia. For example, section 75 of the *Civil Liability Act 1936* (SA) provides:

> In proceedings in which damages are claimed for a tort, no admission of liability or fault is to be inferred from the fact that the defendant or a person for whose tort the defendant is liable expressed regret for the incident out of which the cause of action arose.

In the Northern Territory sections 12 and 13 of the *Personal Injuries (Liabilities and Damages) Act 2003* provide:

Section 12:

> An expression of regret is an oral or written statement by a person:

a) that expresses regret for an incident that is alleged to have caused a personal injury; and
b) that does not contain an acknowledgement of fault by that person.

Section 13:

> An expression of regret about a personal injury made at any time before the commencement of a proceeding in respect of that injury is not admissible as evidence in that proceeding.

The extent to which such provisions are used by health authorities and/or health-care professionals is unknown but can only be encouraged where appropriate.

Time limits or limitation periods

As in most civil litigation, the law imposes time limits or limitation periods for bringing actions in negligence. Such limits will vary depending on the type of damage or injury that is being alleged. For example, in relation to a claim for damages for 'dust diseases' such as mesothelioma alleged to have been caused by exposure to asbestos particles, no limitation period is set in New South Wales, the Northern Territory or Victoria.[84]

As a consequence of the Ipp Report, changes have been made by the states and territories to the relevant legislation setting limitation periods with respect to claims for personal injury or death. As a general rule, there is now a period of 3 years in which plaintiffs can commence such claims.[85] What is critical is determining when the limitation period begins to run. As a general rule it is when the plaintiff suffers the damage complained of, although there are different approaches as to how that is determined between the states and territories. For example, in the Australian Capital Territory, Northern Territory, Queensland and South Australia the limitation period starts to run from the time the injury occurred. In New South Wales and Tasmania the time begins to run from the date when the personal injury is 'discoverable', and in Victoria and Western Australia it runs from the date on which the action 'accrues'. Section 50D of the *Limitation Act 1969* (NSW) defines 'discoverable' as follows:

1) For the purposes of this Division, a cause of action is ***discoverable*** by a person on the first date that the person knows or ought to know of each of the following facts:
   a) the fact that the injury or death concerned has occurred,
   b) the fact that the injury or death was caused by the fault of the defendant,
   c) in the case of injury, the fact that the injury was sufficiently serious to justify the bringing of an action on the cause of action.
2) A person ***ought to know*** of a fact at a particular time if the fact would have been ascertained by the person had the person taken all reasonable steps before that time to ascertain the fact.
3) In determining what a person knows or ought to have known, a court may have regard to the conduct and statements, oral or in writing, of the person.
4) To remove doubt, a compensation to relatives action is not discoverable before the date of death of the deceased.

In Victoria reference to the date when the action 'accrues' is provided for in section 5(1AA) and (1A) of the *Limitation of Actions Act 1958* which states that a cause of action accrues on the date on which the person first knows:

a) that he suffered those personal injuries, and
b) that those personal injuries were caused by the act or omission of some person.

As a general rule, the prescribed limitation period for children does not begin to run until the child reaches the age of 18 years. Accordingly, depending on the limitation period applying in the particular state or territory, the young person would have until the age of 21 years where the limitation period is 3 years and until the age of 24 where the limitation period is 6 years.

Given the variations that can arise in relation to limitation periods for negligence actions involving personal injury or death, it is important that advice be sought as soon as possible where a claim is contemplated in order to avoid problems with limitation periods.

The legislation of all of the states and territories provides the courts with a discretion to extend limitation periods in certain circumstances. Not surprisingly, it is not a discretion that is lightly exercised. There would have to be cogent and compelling reasons to support an application to file a claim beyond the limitation period set.

Defences to an action in negligence

When a plaintiff brings an action against a defendant alleging negligence, it is necessary for the plaintiff to establish his or her allegation on the balance of probabilities. Equally it is possible for the defendant to refute the allegation of negligence made by the plaintiff by raising certain defences.

In raising a defence it is necessary for the defendant to establish that defence on the balance of probabilities by calling the appropriate evidence. The general defences available to a defendant are briefly summarised below.

A general denial and rebuttal of the allegation

This is the most common form of defence raised and arises where the defendant can establish that:

- no duty of care was owed to the plaintiff, *or*
- whatever the defendant did was reasonable in all the circumstances in that it was shown to be 'widely accepted' by 'peer opinion' to be 'competent professional practice', *or*
- the plaintiff suffered no damage, *or*
- there was no causal relationship between the breach of the duty of care alleged and the damage to the plaintiff, *or*
- the damage being complained of was too remote from the negligent act.

If the defendant can establish one or more of the above principles he or she will be able to successfully resist any claim for compensation made by the plaintiff.

Contributory negligence

This is often referred to as a 'partial defence' to an action in negligence. As far as common-law principles are concerned, if the defendant succeeds in establishing contributory negligence as a defence, this operates as a total defence. This situation has now been changed by statute in all states and territories so that the essence of contributory negligence as a defence is to apportion a determined percentage of blame to the plaintiff for the damage caused and penalise the plaintiff by reducing the damages accordingly.[86] The determination of apportionment of blame, if any, is done by the judge but the defendant must establish it on the balance of probabilities. At first glance it is often presumed that contributory negligence is where a person assists (or contributes to) the negligent act of the defendant. What the expression means is that the defendant alleges that the actions of the plaintiff in the incident complained about also amount to negligence and have contributed to the damage which resulted.

A good example of a case in which contributory negligence is often raised as a partial defence is that of personal injury involving the failure of a passenger in a motor vehicle accident to wear a seat belt. For example, a front seat passenger in a motor vehicle fails to secure the seat belt and, as a result of the driver's negligence, an accident occurs. On impact the passenger is thrown forward through the windscreen of the car onto the bonnet, suffering severe facial lacerations and head injuries. The passenger sues the driver of the motor vehicle for negligence and, as part of the damages complained of, seeks compensation for all of the consequences of the facial and head injuries suffered.

In his defence, the driver alleges that if the passenger had worn a seat belt, the facial and head injuries he or she is now complaining about would not have been sustained and that this is a fact readily known or which ought to have been known by the passenger. Therefore, the failure or negligence on the part of the passenger to wear a seat belt has contributed to the damage he or she is now complaining about. In raising such a defence it would be necessary to call evidence in support of it. If the driver, as the defendant, can successfully establish the partial defence of contributory negligence, the court is entitled to reduce, by a percentage, the damages awarded. This percentage, as determined by the court, represents the plaintiff's share or portion of the fault in causing the damage being complained of. Damages are reduced in percentage terms so that the court may determine that the plaintiff was 10 percent (or 50 percent or 85 percent, and so on) to blame for the damage and reduce the amount awarded accordingly.

The partial defence of contributory negligence may have some relevance to hospitals and health centres if it can be established that, in a negligence action brought by a patient, what the patient did or failed to do was also negligent and accordingly contributed to the damage the patient is complaining about. For example, where a plaintiff failed to keep his or her appointments with the doctor, or where a plaintiff failed to properly describe the nature of his or her symptoms to the doctor or nurse concerned. As always, it would depend on the facts and circumstances of the matter and, if the defence is raised, the defendant must establish it according to the civil standard of proof, that being on the balance of probabilities.

Voluntary assumption of risk

This defence is commonly known as the defence of *volenti non fit injuria* ('no injury is done to one who voluntarily consents'). Its basis is that no action in negligence can arise if the plaintiff knowingly and willingly consents to run the risk of injury. A person who participates in a dangerous sport cannot complain if he or she is injured, as the defence of *volenti* would claim that, in agreeing to participate in such dangerous activities, the person had voluntarily assumed the risk of injury.

For a defendant to raise *volenti* as a defence, he or she must establish, on the balance of probabilities, that the plaintiff knew of and understood the risk of injury arising from the activity undertaken and, knowing and understanding that, freely and voluntarily consented to run the risk of injury by participating in that activity.

Not surprisingly, this defence arises most often in relation to sporting activities. It should be noted, however, that such a defence will not succeed if a person in the course of a game goes beyond the normal 'rough and tumble' of a particular sporting activity and recklessly or negligently injures a fellow player. In such a situation the defence of *volenti* will fail. Damages have been awarded to people injured in sporting activities where they have established that they were exposed to an unreasonable risk of harm or where a fellow player has acted recklessly and beyond what would be considered reasonable in all the circumstances and which has resulted in injury.

It should be noted that as a result of the changes to the civil liability law, a defendant is not liable in negligence for harm suffered by a plaintiff where the injury was as a result of an 'obvious risk' of a dangerous recreational activity (such as any sport) engaged in by the plaintiff. Accordingly, the plaintiff would bear the onus of proving that he or she was not aware of the 'obvious risk' raised as a defence by the defendant.

As much as it may appear to be an attractive defence for hospitals and healthcare personnel, the courts have long ago determined that any attempt to raise such a defence by such parties is ethically and legally indefensible as being contrary to public policy.

Vicarious liability

In determining liability in many situations it is necessary to consider whether the financial responsibility for an individual's personal liability can be transferred to another person. In determining this issue the courts will have regard to the principles encompassed within the doctrine of vicarious liability.

The doctrine of vicarious liability is a common-law doctrine of long standing. It provides that, where an employee has been negligent in the course and scope of employment and a person suffers damage as a result, the employer will be made liable. That does not mean that the personal liability of the individual is transferred to the employer but that the responsibility for the negligent act is directed at the employer. In simple terms, that means that the employer has to pay the plaintiff the sum of money awarded by the court as a result of the employee's negligent act.

Historically the doctrine has its origins in the old master and servant relationship, which made the master liable for all the wrongs of his servants. Over the years, with social, industrial and technological change, the master/servant terminology has been replaced by employer/employee relationship. Despite the change of terminology, the doctrine of vicarious liability has been retained insofar as imputing liability within the employer/employee relationship. It can be very difficult for employers to avoid liability under this doctrine, primarily for practical economic reasons. If the individual employee were to remain financially liable to compensate the innocent plaintiff who has been badly damaged, many such plaintiffs would go without, for the simple reason that it is not worth suing most employees because they do not have any worthwhile financial resources. Obviously the employer is in a better financial position, better able to plan and insure for such losses and better able to distribute such losses through their financial system.

In pursuing an attitude of almost strict liability against the employer in this area, the law has also provided the employer with the power to recover such money paid out, either wholly or in part, from the employee concerned. The right to seek total recovery of monies paid is known as seeking an indemnity from the employee concerned; the right to seek partial recovery is known as seeking a contribution. The right of the employer to pursue such remedies and the practical considerations attached to such an action will be dealt with following an examination of the major principles of the doctrine itself.

When considering whether the employer is vicariously liable for the negligent acts of another, the following principles have to be determined:

- that the person was an employee;
- that the negligent act arose in the course and scope of employment.

Who is an employee for the purposes of the doctrine of vicarious liability?

For the purposes of the doctrine of vicarious liability, an employee has to be distinguished from what is traditionally referred to as an independent contractor. The closest analogy to an independent contractor is the self-employed person, although as far as the law is concerned this may not necessarily be the case. In the first instance the way to distinguish between an employee and an independent contractor is to apply what the law refers to as the *control test*. Generally speaking, a person is an employee if the employer exercises authority over that person in the performance of the person's work and is able to give the person instructions in relation to such work. In most situations other indicators of control can be the answers to the following questions:

- Is the person paid a weekly or regular wage that is tax deducted?
- Is the person entitled to the benefits of an industrial award; for example, annual leave, sick leave?
- Does the employer provide the necessary plant and equipment to enable a person to carry out the duties that person is engaged to perform?

If the answers to the above questions are in the affirmative there is probably no doubt that the person concerned is an employee. The great majority of people working in differing types of employment are clearly employees, and nurses and midwives are no exception.

The question as to whether a person is an employee or an independent contractor may not always be readily apparent, even when using the control test, as particular circumstances may exist in some cases which make it difficult to determine.

For example, in a dispute between a trapeze artist and the management of Wirth's Circus, the question arose whether the trapeze artist was an employee or an independent contractor. The traditional tests of control at first glance seemed to indicate that the artist was an independent contractor, in that the professional skill, judgment and expertise required of a trapeze artist could not be under the control of somebody in authority. However, the High Court of Australia determined that the trapeze artist was an employee and in making that finding the court stated:

> The duties to be performed may depend so much on professional skill or knowledge … or the necessity of the employee acting on his own responsibility may be so evident, that little room for direction or command in detail may exist. But that is not the point. *What matters is lawful authority to command so far as there is scope for it*.[87] [emphasis added]

A more recent decision where the control test was considered in determining whether a person was an employee or independent contractor is the High Court decision in *Hollis v Vabu Pty Ltd*.[88] In that matter, the plaintiff (Mr Hollis) was knocked over and injured by a bicycle courier. The courier was identified only by his uniform, on which appeared the words 'Crisis Couriers'. That name was the trading name of the defendant. Relying on the doctrine of vicarious liability, Mr Hollis sued the defendant as the courier's employer. The defendant argued the courier was an independent contractor and therefore it was not liable. On appeal, the High Court disagreed, determining they were employees, saying that:

> … considerations respecting economic independence and freedom of contract are not, with respect, determinative of the legal character of the relationship between the bicycle courier and Vabu as disclosed by the evidence.[89]

The High Court identified the following matters as being relevant to considerations of control:

a) The couriers were not providing skilled labour or labour which required special qualifications. A bicycle courier was unable to make an independent career as a free-lancer or to generate any 'goodwill' as a bicycle courier.
b) The evidence showed that the couriers had little control over the manner of performing their work. They were required to be at work by 9.00 am and were assigned in a work roster according to the order in which they signed on. Couriers were not able to refuse work.
c) The facts showed that couriers were presented to the public and to those using the courier service as emanations of Vabu. They were to wear uniforms bearing Vabu's trading logo of Crisis Couriers.

d) There were important considerations of deterrence. Reference was made to findings of fact in respect of the knowledge of Vabu as to the dangers to pedestrians presented by its bicycle couriers and the failure to adopt effective means for the personal identification of those couriers by the public. One of the major policy considerations in other court decisions to support a finding of vicarious liability was deterrence of future harm by fixing the employer with responsibility for the employee's wrongful act, even where the employer is not negligent, as it may have a deterrent effect.

e) Vabu superintended the couriers' finances. That is, Vabu produced pay summaries and couriers were required to dispute errors by 6.00 pm Friday of the same week. There was no scope for the couriers to bargain for the rate of their remuneration. Vabu was authorised to hold for 6 weeks the last week's pay of a courier against any overcharges, unpaid cash jobs or outstanding insurance claims. Moreover, in relation to leave periods at Christmas and Easter, Vabu stipulated that '[n]o annual leave will be considered for the period November to Christmas Eve, nor for the week prior to Easter. Leave requests will be considered in accordance with other applications and should be submitted to the manager in writing at least 14 days prior'. This suggested that their engagement by Vabu left the couriers with limited scope for the pursuit of any real business enterprise on their own account.

f) The situation in respect of tools and equipment was that apart from providing bicycles and being responsible for the cost of repairs, couriers were required to bear the cost of replacing or repairing any equipment of Vabu that was lost or damaged, including radios and uniforms.

g) There was considerable scope for the actual exercise of control. Vabu's whole business consisted of the delivery of documents and parcels by means of couriers. Vabu retained control of the allocation and direction of the various deliveries. The couriers had little latitude.[90]

The application of the control test in relation to claims of negligence by the medical staff of hospitals ran into considerable legal difficulties for many years. The courts took the view that, although hospitals were required to exercise due care in the selection of staff, they could not be made liable for the negligence of medical and nursing staff in carrying out their professional duties, because they were unable to control them in the exercise of their professional judgment. Accordingly, hospital management could not be made vicariously liable for the negligent acts of such staff. Although such a view prevailed early this century, it has gradually been eroded as the courts have sought to overcome the limitations of the control test by other arguments. The alternative test ultimately devised by the courts is known as the *organisation test*. The question to be asked is: Is the person part of the employer's organisation? Such a test has also been applied in the context of the following question: Is the person's work subject to coordinational control as to the *where* and *when* rather than the *how*?[91]

The attitude taken by the courts now is that hospitals are liable for the negligence of all staff, including nurses, midwives, resident medical officers, part-time

anaesthetists and consultants on the basis that they are part of the hospital organisation. The liability of hospitals for such staff was clearly spelled out in a decision of the English Court of Appeal in 1954 in a case known as *Roe v Minister for Health*.[92] Although Mr Roe was unsuccessful in his action against the hospital and the anaesthetist for other reasons, the appeal court did spell out clearly its view on the liability of hospitals for staff such as anaesthetists. In relation to that issue, one of the appeal judges stated:

> In the first place I think the hospital authorities are responsible for the whole of their staff, not only for the nurses and doctors but also for the anaesthetists and the surgeons. It does not matter whether they are permanent or temporary, resident or visiting, whole-time or part-time. *The hospital authorities are responsible for all of them*. The reason is because, even if they are not servants, they are the agents of the hospital to give the treatment. The only exception is the case of consultants or anaesthetists selected and employed by the patient himself.[93] [emphasis added]

The views expressed in that passage would have general application in Australia. In addition, the organisation test has been applied in the decision of the New South Wales Court of Appeal in 1980 in *Albrighton v Royal Prince Alfred Hospital*.[94] For the purposes of comment on the issue of vicarious liability the relevant facts are set out below.

EXAMPLE: *ALBRIGHTON V ROYAL PRINCE ALFRED HOSPITAL*

In 1971, a 15-year-old girl was admitted to Royal Prince Alfred Hospital for corrective surgery to straighten and lengthen her spine, involving a procedure known as halopelvic traction. The girl had suffered, from birth, a deformity of the spine called kyphoscoliosis, spina bifida, and she had a large hairy naevus on her lower back over her spine, which was some indication of the possibility of 'tethering' — adherence of the spinal cord to the adjacent structures with consequent risk of rupture and the possibility of paraplegia if traction were applied.

During her admission, the young girl was attended by Dr Tyer and Professor Gye, a neurosurgeon, who was called for a second opinion by Dr Tyer. The halopelvic frame was fitted and traction applied on five succeeding days. As a result of the treatment, the spinal cord was severed and the young girl became a paraplegic.

The young girl eventually brought an action against the hospital and the two doctors for negligence. The action against the hospital was based squarely on the hospital's vicarious liability for the actions of the two doctors. When the matter came before the Supreme Court in the first instance the judge upheld the view expressed by the hospital's barrister, disclaiming vicarious liability on the part of the hospital. In that decision it was held that:

> … a hospital in New South Wales (in possible contradistinction, in certain circumstances, from a hospital in England) will be vicariously liable for the negligence of a doctor in relation to his patient in the hospital only if, in addition to having the power to direct the doctor as to what he is to do, the

> hospital also has the power, whether or not it exercises it, to direct him as to the manner in which he is to do his work.[95]

That proposition was quite firmly overturned when the case went on appeal to the New South Wales Court of Appeal. In dealing with that point the appeal judges held as follows:

> The concept that a hospital fulfils its duty of care to persons treated in it by selecting and appointing competent medical staff, and the concept that a hospital is not responsible for the tortious conduct of its medical staff in the course of their duties in the hospital, unless it can be shown that the hospital has the power (whether or not it exercises it) of directing them as to the manner in which they should carry out their work (the control test) *have both long since been eroded*.[96] [emphasis added]

The control test is not now acceptable in its full vigour. Today, the uncontrollability of a person who is part of an organisation, as to the manner in which that person performs his or her task, does not preclude recovery from the organisation, and does not preclude the finding of a relationship of master and servant, such as to make the former vicariously liable for the negligence of the latter.

The appeal judges went on to say that, in order to determine the relationship between the hospital and the medical practitioners, in this instance, it was necessary to look at the evidence in order to determine whether the hospital was vicariously liable for any negligence proved against the medical practitioners concerned. On this particular occasion that evidence comprised the account of the activities of the doctors within the hospital; their use of and compliance with hospital forms and routines, and the operation of the hospital by-laws.

When a patient is a private patient and the doctor is employed directly by the patient, the hospital may not be liable for the particular actions of the doctor. It would depend very much on the facts and circumstances of each case. However, if the damage caused to the patient came about as the result of faulty hospital equipment being used by the doctor, the hospital would clearly be liable.

EXAMPLE: *ELLIS V WALLSEND DISTRICT HOSPITAL*

The decision of the New South Wales Court of Appeal in *Albrighton v Royal Prince Alfred Hospital* in relation to the application of the principle of vicarious liability became the subject of further judicial comment in the New South Wales Court of Appeal decision in *Ellis v Wallsend District Hospital*.[97] The relevant facts of this matter are that Mrs Ellis was a 43-year-old woman when she had a cervical posterior rhizotomy of nerve roots at C2-6. Post-operatively she became a quadriplegic. The Court of Appeal determined that Dr Chambers had been in breach of his duty to Mrs Ellis by failing to warn her of the possibility of paralysis arising from the proposed surgery; further, that Mrs Ellis had relied on his advice in agreeing to undergo the surgery and that she would not have agreed to undergo the surgery if she had been properly warned. Thus, Mrs Ellis' reliance on Dr Chambers' advice had caused her to suffer the paralysis arising from the surgery which she would not have had if she had been properly warned by Dr Chambers of the risks involved.

The decision of the Court of Appeal in establishing negligence on the part of Dr Chambers was a somewhat hollow victory for Mrs Ellis. As the facts established, by the time the matter came to trial Dr Chambers had died. Mrs Ellis had been unable to recover from Dr Chambers' estate all of the compensation she believed was appropriate having regard to her damage because of the financial limitations of the professional indemnity policy which Dr Chambers had taken out. Accordingly, for Mrs Ellis to obtain additional compensation she had to establish that the hospital was vicariously liable for the negligence of Dr Chambers or that the hospital was personally and directly liable. She failed on both counts.

The decision of the Court of Appeal to dismiss Mrs Ellis' appeal was made by the majority decision of two out of the three judges hearing. In dismissing Mrs Ellis' appeal the court was at pains to distinguish their decision from that in *Albrighton* above. In doing so the major fact which the court relied upon was expressed as follows by Samuels JA:

> So far as the treatment of the appellant (Mrs Ellis) is relevant, there is a critical distinction between the facts in *Albrighton* and those in the present case. The patient in *Albrighton* went directly to the hospital for treatment and advice and first saw the second defendant in the outpatients department; and he, in due course, consulted the third defendant about her case.[98]

The 'critical distinction' in relation to Mrs Ellis was that she had always sought treatment directly from Dr Chambers in his private consulting rooms.

There was considerable evidence produced in the appeal seeking to establish an employer/employee relationship as between Wallsend District Hospital and Dr Chambers. Reliance was placed on the Model By-Laws and Rules of Public Hospitals which governed the relationship and largely set out the agreement as between Dr Chambers and the hospital. On that issue the majority decision of the court determined that Dr Chambers' relationship with the hospital in relation to his treatment of Mrs Ellis was not one of employer and employee but rather that he was conducting his independent practice as a neurosurgeon. In coming to their decision on the existence or otherwise of an employer/employee relationship between the hospital and Dr Chambers, the majority decision of the court had this to say, in part:

> I would therefore approach the matter by seeking an answer to the question: 'In treating the appellant was Dr Chambers acting as the employee of the hospital (that is to say, on the hospital's behalf) or on his own behalf?' … In seeking the answer I must examine all relevant indicia; that is to say all facts capable of elucidating the question, and thus consider the whole of the relationship between the parties.
>
> I must deal with the evidence again, but I can do so this time in a rather more sophisticated way. Dr Chambers at all material times carried on his own business, that is to say, his own specialist medical practice. The performance of surgery was a vital incident of that practice, and required the use of facilities which could be obtained only in a hospital which

> provided operating theatres with their standard fixtures and fittings (I interpolate that Dr Chambers provided other items of the surgeon's kit), together with wards, recovery rooms and trained nursing staff. The list is not exclusive. Without these resources Dr Chambers could not have carried on his practice as a surgeon.
>
> For its part, the hospital needed senior physicians and surgeons in order to fulfil the objects prescribed by by-law 5, that is, 'to establish and maintain hospital facilities and afford relief to sick persons' in accordance with the provisions of the *Public Hospitals Act 1929*, section 3 of which defined 'relief' to include treatment of disease or injury and the provision of medical and surgical attention … Dr Chambers undertook to treat free of charge those patients who had applied directly to the hospital for relief, in return for operating privileges, nursing care and accommodation in respect of those of his own patients whom he would book into the hospital. By 'his own patients' I mean those who had consulted Dr Chambers directly, or had been referred to him by other doctors, and who had agreed to pay him a fee for his services. They would pay the hospital for nursing and other care and for accommodation as private or intermediate patients.
>
> Dr Chambers received no remuneration from the hospital. The hospital through its board and the chief executive officer … retained that slight degree of control over the activities of the honorary medical staff … necessary, as I have said, to maintain administrative efficiency and integrity …
>
> Considering the totality of the relationship between the parties I conclude that it points convincingly to the conclusion that in treating the appellant Dr Chambers was engaged in his own business and not the hospital's. He was conducting his independent practice as a neurosurgeon and his relationship with the hospital was not one of employer and employee.[99]

The comments of the judge who disagreed with the majority view in relation to this point are in such contrast as to require careful consideration. In his minority decision on this issue Kirby P stated, in part, as follows:

> The relationship between Dr Chambers and the hospital was defined by the Model By-laws and Rules for Public Hospitals which were admitted into evidence without objection …
>
> In my opinion, these by-laws, for mutual benefit, tied Dr Chambers inextricably into the organisation of the hospital. True, he could not be directed on how to 'hold the knife'. But neither could the other professional staff be so directed. He was integrated into the discipline and direction of the hospital. What he did in his rooms was his affair. But when he came into the hospital, he was part of the hospital. When working on its premises, he was part of its integrated medical team. Nothing could demonstrate this more clearly than the consent form which patients (including Mrs Ellis) were required to sign upon their admission to the

> hospital. It is set out in full in the judgment of Samuels JA. It includes the statement: 'I understand that an assurance has not been given that the operation will be performed by a particular surgeon'.
>
> This showed that, although a patient would have every expectation that her own doctor would perform the operation, once she came into the hospital her relationship with Dr Chambers changed. She was thereafter (as was he) under the discipline, and subject to the requirements, of the hospital.[100]

In addition to the issue of vicarious liability, the Court of Appeal was also required to consider whether the hospital was directly liable for the negligence of Dr Chambers. Once again, on this issue the judgment presented two contrasting views. The majority decision maintained the consistent approach it had adopted in rejecting the application of the principle of vicarious liability and rejected the argument that the hospital was directly liable for Dr Chambers' negligence. In considering the facts of the matter before them, and distinguishing it clearly from *Albrighton*, the majority decision reads, in part, as follows:

> … a hospital is bound to ensure that reasonable care is used in providing the treatment which it undertakes to carry out; but that duty does not extend to treatment which is performed by a doctor pursuant to a direct engagement with the patient, and not on behalf of the hospital.
>
> In my opinion therefore while proof of the relationship of hospital and 'patient' will generate a special duty of some kind, closer scrutiny of the facts is necessary in order to establish its scope …
>
> In the present case, however, it is quite clear that the appellant did not knock at the hospital's door … It was not the hospital's door but the door of the late Dr Chambers' consulting rooms upon which she knocked, and it was that door which was opened to her and which admitted her to the treatment and advice upon which she thereafter principally relied. I do not think it can be doubted but that it was Dr Chambers and not the hospital to whom the appellant looked for medical care. The hospital, for reasons which I have already discussed and will not repeat, was merely the place in which surgical procedures which he had recommended and which the appellant had agreed to undergo were performed by Dr Chambers.[101]

The majority decision already identified a difference between the facts and circumstances of *Albrighton* and *Ellis* — predominantly on the issue that in *Albrighton* the patient had attended the hospital outpatient clinic for treatment in the first instance whereas Mrs Ellis had always sought treatment directly from Dr Chambers in his private consulting rooms. The minority decision of the Court of Appeal on the issue of the hospital's direct liability again contrasted strongly with the majority decision. In his decision on this issue, Kirby P stated, in part, as follows:

> It is wrong, in my opinion, to present the respondent hospital as the mere venue for the performance by Dr Chambers of his private surgical procedures. Such a conclusion flies in the face of the consent form, the

> by-laws and the mutually beneficial arrangement under which Dr Chambers operated at the hospital.
>
> Accordingly, if there was negligence on the part of Dr Chambers, it was negligence for which the hospital was liable. It was so liable either because it was vicariously liable for his negligence as a member of its honorary medical staff. Or it was liable directly to the patient which it could not fulfil merely by delegating its operation to a member of the honorary medical staff. As Reynolds JA said in *Albrighton*, the hospital was not a 'mere custodial institution designed to provide a place where medical personnel could meet and treat persons lodged there, as it might have been regarded in years long since gone by' (at 562). It was, to the contrary, an integrated institution. And Dr Chambers was part of it.[102]

Given the contrasting opinions in *Ellis* there is no doubt that future decisions on the issue of vicarious and direct liability of hospitals for staff or healthcare practitioners who use their premises and facilities, howsoever described, will very much be determined on the particular facts and circumstances of the situation. The majority decision in *Ellis* does have implications for visiting medical staff vis-a-vis their relationship with a particular hospital. Given the facts of the case, no particular implications arise in relation to those nurses and midwives who are employees at law and who do not generally change their employee status to that of independent contractor as can occur in relation to medical practitioners. The implications may well be different, however, for the nurse or midwife who may be found to be an independent contractor. The most obvious example where that might arise would be in relation to independent or homebirth midwives.

The predicament for Mrs Ellis in the majority decision was that she was unable to be fully compensated because Dr Chambers was not fully indemnified by insurance. Such an outcome was clearly most unfortunate, particularly when it is remembered that as Mrs Ellis lost her appeal she was required to pay the hospital's approved legal costs in defending the action. On this issue Kirby P said:

> Where, as here, the honorary surgeon was not fully indemnified, the question is where the law should assign the loss. It is preferable, in my view, that it should be fixed upon the hospital which has far better facilities (and can be expected) to insure itself fully. That insurance can readily cover all staff — honorary and otherwise. Only in this way can the patient be protected from the predicament which now faces Mrs Ellis because of the underinsurance of the late Dr Chambers.[103]

The situation such as that referred to above by Kirby P is clearly a factor which must influence the application and interpretation of the principle of vicarious liability.

What constitutes the course and scope of employment?

The principle of vicarious liability clearly envisages that the employer's liability is confined to those negligent acts that arise within the course and scope of an employee's work. It is not uncommon to find that the notions of what constitutes

the 'course of employment' and the 'scope of employment' are considered separately. It is not necessary to make such a rigid distinction for the purposes of this text and, accordingly, they are considered together. The attitude of the courts as to what constitutes the 'course and scope of employment' is not subject to precise definition and has generally tended to be given the widest possible application, probably largely as a result of the courts' eagerness to ensure that plaintiffs will not go uncompensated because of the individual employee's inability to pay.

Generally speaking the 'course and scope of employment' will embrace all the authorised acts of an employee, even if such authorised acts are performed in an incorrect and unauthorised way. For example, if a nurse or midwife administered medications contrary to authorised hospital procedure and protocol and, in doing so, negligently gave the wrong drug, and the patient suffered damage, the hospital would still be vicariously liable. The giving of medications is well recognised as being part of the work of a nurse or midwife and the fact that she or he gives them out in an unauthorised way contrary to the organisation's policy does not allow the hospital to escape its liability.

The result of that example might well be different if the nurse prescribed the medication. As a general rule, nurses and midwives are not authorised to prescribe medications (nurse practitioner provisions aside). Should a nurse or midwife routinely take it upon herself or himself to prescribe medication, and a patient suffered damage as a result, then it could be argued that she or he had gone outside the course and scope of employment and the hospital would not be vicariously liable for the damage caused and, more significantly, the payment of any compensation awarded.

Alternatively, an emergency situation might well be different. For example, in areas such as intensive care, registered nurses are sometimes authorised to administer, in the absence of a medical practitioner, a medication regime which may be given in certain life-threatening situations. The authority for such emergency treatment should be found in the appropriate hospital protocol, drawn up and approved by the medical officers concerned. Where initiation of the administration of medication by registered nurses in emergency situations is sanctioned in appropriate circumstances, such actions will clearly come within the course and scope of employment. The same situation may arise in the labour ward where a midwife is authorised by a clinical protocol to administer certain medications in an obstetric emergency. As always, it is necessary to look at each case in the light of its own particular facts and circumstances. To take it outside the course and scope of employment, an employee's actions must consist of more than doing an act in a way or at a time that is prohibited by the employer. The employee's actions must also be so totally unrelated and removed from his or her normal course of employment that the employee is put, on the occasion in question, 'in the position of stranger' vis-a-vis his or her employer.[104]

When an employee goes outside the course and scope of employment it is often said that the employee is out on a 'frolic of his/her own'. As far as nursing staff are concerned the temptation to embark on such a frolic more often than not involves the use of motor vehicles and, in so doing, community nurses are the most likely to be affected.

Problems arising from the use of motor vehicles provided by the employer

When an employer provides an employee with a motor vehicle for the purposes of carrying out his or her work, the general intention is that the vehicle will be used by the employee only in the course of employment. A motor vehicle is more often the cause of an employee going outside the course and scope of employment and embarking on a 'frolic of his/her own' because its use is relatively easy and temptingly convenient. The question to be considered is to what extent, if at all, can an employee driving the employer's motor vehicle diverge from his or her normal work journey and still remain within the course and scope of employment. The attitude taken by the courts in such matters is to consider the extent and purpose of such divergence, bearing in mind that practical considerations do not often permit the most direct route to be used. The following are examples of different views expressed by the courts.

1) A long-distance truck driver who turned off the highway to go to a hotel to get a drink negligently collided with a motor cycle. The court determined that the driver was acting in the course of employment, because it was reasonable to diverge from the highway for the purpose of obtaining refreshment. Accordingly the employer was vicariously liable. The case is reported as *Chaplin v Dunstan* (1938).[105]
2) A courier was sent to deliver wine and collect certain empty bottles. On the return journey he agreed to give a friend a lift in a different direction from the usual return journey. An accident occurred, caused by the courier's negligence. The court determined that the courier had diverged from the course of his employment and had undertaken a completely different journey. Accordingly the employer was held not to be vicariously liable. The case is reported as *Storey v Ashton* (1986).[106]

These examples illustrate that an employee is not required to take the most direct route, and that a reasonable divergence from that route will not necessarily take the employee outside the course and scope of employment. Once again, it would be necessary to consider the facts and circumstances of each case, having regard to the views expressed by the courts.

A further problem arises when an employee gives a lift to a person while engaged in the course of employment and does not diverge from it. The following is a hypothetical example. A community nurse is driving her employer's motor vehicle back to the community health centre after completing her visits for the day. It is mid-afternoon in summer and extremely hot. On the way back she notices an elderly lady walking slowly along the footpath. Concerned for her because of the heat, the nurse pulls over and asks the lady where she is going and if she can help. As it happens, the elderly lady is on her way to the outpatients' department at the local hospital. Coincidentally, the community health centre is situated in the grounds of the hospital and the nurse offers to drop her off. The elderly lady agrees and gets into the car. On the journey to the hospital the nurse negligently collides with another vehicle and the elderly lady is injured. The nurse's employer has consistently

made it clear that staff are not to give lifts to people, other than clients on authorised journeys.

In the hypothetical example given, the nurse was clearly doing what she was not authorised to do, and yet her actions could not be said to be so totally unrelated or removed from her normal course of employment as to place her in the position of a stranger vis-a-vis her employment. In addition, at no time did the community nurse diverge from her route, which she was following in the course and scope of her employment. Would the employer be vicariously liable in such a situation?

Although no situations precisely resembling the hypothetical example outlined above have been dealt with by the courts on a reported basis, the courts have considered the position where an employee engaged in the course of employment gives a lift to a stranger contrary to the employer's instructions. In such situations, the courts have generally come to the view that the employer was not vicariously liable, on grounds that the employee was on a frolic of his or her own as regards the passenger.

However, the practical outcome in such situations can sometimes render the determination of the employer's vicarious liability or otherwise an academic exercise. In the hypothetical example outlined above, the elderly lady passenger who suffered personal injury would be able to make a claim against the registered owner's compulsory third party insurance cover — notwithstanding that the employer is probably not vicariously liable.

Part and parcel of motor vehicle ownership in every state and territory is the legal necessity that the vehicle be registered. A proportion of the registration fee paid by motor vehicle owners each year is allocated to the relevant state, territory or Commonwealth government insurance authority. This is done to provide funds for the purposes of compensating people injured in motor vehicle accidents caused as a result of a motorist's negligent driving. The large number of people who are killed or seriously injured on our roads each year necessitated that some steps be taken to ensure that they or their relatives had recourse to some form of compensation. As a recognition of that necessity state, territory and Commonwealth parliaments introduced compulsory third party motor vehicle insurance as part of the motor vehicle registration fee. This compulsory third party insurance covers only negligence-based claims for personal injury. (Claims for property damage to motor vehicles must be covered by additional comprehensive insurance.)

The implications of the doctrine of vicarious liability are not always academic. For example, a community nurse was given permission to drive the employer's car to and from work but was advised otherwise not to use it for personal use. During days off the nurse used the car to go and visit friends some distance away. On the return journey an accident occurred as a result of the nurse's negligent driving. Although no one was injured, extensive property damage was done to two other vehicles. The owners of the two vehicles claimed compensation for the cost of repairing their vehicles from the owner of the vehicle that 'caused' the accident — the nurse's employer.

In the circumstances outlined, the employer would be able to defend such a claim. The nurse was clearly not acting in the course of employment, having

embarked on a frolic of the nurse's own, contrary to the employer's express instructions. Accordingly, the employer would not be vicariously liable and the vehicle owners would have to recover their damages from the nurse.

In all circumstances it would be sensible for members of nursing staff who drive a motor vehicle owned by their employer to obtain written guidelines from the employer as to what person or persons may be transported in the motor vehicle and whether the motor vehicle may be used for private as well as business use.

In situations where the employer is found to be vicariously liable and has to compensate the plaintiff, the common law has provided the employer with the right to recover the money paid out, either wholly or in part, from the negligent employee. The employer's right to recover such monies will now be considered.

Contribution and indemnity

This common-law right is largely self-explanatory when viewed within the context of vicarious liability. The employer has the right to seek total financial indemnity from the negligent employee, if it can be established that liability for the negligent act rests solely with the employee. The courts have also determined that such a right can arise in a contractual sense — that is, between employer and employee. In the decision known as *Lister v Romford Ice and Cold Storage Co Ltd*,[107] the court was asked to consider whether an employer had the right to recover damages from an employee who had driven the employer's motor vehicle negligently in the course of employment and injured a third party. The third party sought damages from the employer based on the negligent driving of the employee and was successful. The employer then claimed an indemnity from the negligent employee based on, amongst other points, breach of contract — and was successful. The decision, which went all the way on appeal to the House of Lords, stated that:

> … the employee–driver of the motor vehicle was under a contractual duty to his employer to exercise reasonable skill and care in driving the vehicle and, prima facie, he was liable to his employers in damages for breach of contract if he should fail to exercise that skill and care and if, as a result of his failure, the employer were held liable in damages to a plaintiff.[108]

Quite apart from the right to be indemnified, the employer can also seek a financial contribution from the employee to the extent of the employee's liability, if it can be established that liability for the negligent acts rests partly with the employee.

At first glance such common-law rights would appear somewhat harsh and punitive. Admittedly, the decision in *Lister v Romford Ice and Cold Storage Co Ltd* can only be described as controversial and has been abrogated in Australia. Reality reveals that, in Australia, as a matter of common policy, employers do not pursue their common-law right to recover a contribution or indemnity from employees and that damage caused by such accidents is covered by insurance taken out by employers. In fact the Commonwealth Parliament and the parliaments of New South Wales, the Northern Territory and South Australia have passed legislation which seeks to prevent employers from recovering monies from employees which the employers have been required to pay out as a result of being found vicariously

liable.[109] No such protection exists for the employee if the negligent act arises from the employee's serious and wilful misconduct. What would be deemed to be serious and wilful misconduct is not defined. Such legislation clearly affords a degree of protection to the employee together with the common policy approach of employers referred to. However, in those states and territories with no legislative protection, the common-law principles of contribution and indemnity still prevail, although, as a matter of policy, it would be surprising if such a right was pursued in the courts.

Notwithstanding the doctrine of vicarious liability, it is still open to the plaintiff to bring his or her action against the employee directly if he or she so chooses, thereby effectively bypassing the employer as a source of financial compensation. This decision would, for all practical purposes, be constrained by the plaintiff's need to ensure that, if he or she is going to succeed in the action, the employee has sufficient personal financial resources to make such a task worthwhile. More often than not the plaintiff will pursue the employer as the better financial risk. Under the South Australian legislation referred to earlier, provision is made that, should the plaintiff bring the action against the employee directly and succeed, the employee can recover the money he or she has to pay from the employer as long as the employee has no other form of indemnity insurance. The New South Wales legislation does not make such provision and certainly there is no such right at common law as far as the other states or territories are concerned.

The employer's personal liability

Apart from the application of the doctrine of vicarious liability, the courts have also imposed a personal liability on the employer directly. That duty cannot be delegated and is known as a non-delegable duty of care. As far as negligence and healthcare is concerned, the attitude taken by the courts has been that hospital and healthcare employers owe a general duty of care to the consumers of the health service. That duty requires that they provide a safe and competent health service and generally do all that is reasonable and proper in the delivery of that service to ensure that patients are not exposed to an unreasonable risk of harm.

Inherent in such a general duty is the duty to employ safe and competent employees and to provide such employees with appropriate procedural guidelines and assistance to allow them to carry out their tasks safely and competently. When a patient or client suffers damage as a result of what a nurse or midwife did or failed to do in carrying out his or her duties, the fault can often be directed at the employer as a breach of the employer's direct personal duty to the patient.

For example, if a trainee enrolled nurse were required to administer complex medications in a busy medical ward because there were no other nursing staff available at the time, and the trainee made an error, the employer would not only be vicariously liable but also personally liable in allowing such a junior and inexperienced member of staff to carry out a task which that staff member was clearly not trained to do. In such a situation, the likelihood that a mistake could be made and damage caused to a patient is very real.

As stated earlier, the doctrine of vicarious liability revolves around the employer/employee relationship. Although the great majority of nurses and midwives working in Australia are employees, as legally understood, some are not. Some are what the law refers to as independent contractors, or as is more commonly understood, self-employed people. The most obvious category of such persons would be independent homebirth midwives or a private duty nurse.

The nurse or midwife as an independent contractor, and his or her liability for negligence, will now be considered.

The nurse or midwife as an independent contractor

Despite the belief of many nurses and midwives, a nursing agency is generally not an employer. While it would be necessary to consider the facts and circumstances (as done in *Hollis v Vabu Pty Ltd* as detailed above) before a conclusive view could be expressed, in most circumstances the agency is an agent for the purposes of finding work for the nurse or midwife, for which it charges the patient or client a commission. If engaged in such a way, a nurse or midwife should maintain his or her own professional indemnity insurance policy — particularly if engaged to work in the patient's own home. In such a work situation, liability for a negligent act causing damage would rest squarely with the nurse or midwife, who would then rely on his or her professional indemnity insurance to pay any damages for which he or she may be found personally liable. The position may not be so clear when an agency nurse is employed to work in a public or private hospital, as frequently happens in times of staffing shortages. If an agency nurse were negligent while employed in such a manner, the hospital would be personally liable if it could be shown that it engaged the services of an agency nurse and then required that nurse to work unsupervised in an area in which it knew, or ought to have known, he or she was not competent to work; for example, an intensive care unit. Alternatively, on the basis of the organisation test within the doctrine of vicarious liability, the hospital would be vicariously liable. However, it would still be open to the plaintiff to bring an action against the nurse on the basis of the nurse's personal liability.

Apart from agency nurses, some nurses and midwives are employed directly by the patient; for example, homebirth midwives. In such a situation, the midwife is clearly an independent contractor and is required to have professional indemnity insurance.

As a general rule, because of the variable nature of the work undertaken, agency nurses as well as homebirth midwives should have professional indemnity insurance.

Professional indemnity arrangements for healthcare professionals

In November 1995, the Commonwealth Government released its final report on compensation and professional indemnity in healthcare.[110] The report dealt with a review of professional indemnity arrangements for healthcare professionals and made the following recommendations (amongst others):

> On balance the Professional Indemnity Review considers that there are strong public policy reasons to support Government legislation requiring all health professionals to have adequate professional indemnity cover as a condition of practice.[111]
>
> …
>
> The Professional Indemnity Review recommends that the Commonwealth and States, through AHMAC (Australian Health Ministers Advisory Council) develop an agreed strategy for making professional indemnity cover (with a defined minimum set of characteristics) compulsory for all health professionals, *either through their own cover, or through adequate cover by their employer in the case of vicarious liability*.[112] [emphasis added]

That recommendation has been acted upon by the states and territories in the context of moving to a system of national registration for healthcare professionals. That system of national registration and the professional obligations arising in relation to it are covered in detail in this text in the chapter dealing with the professional regulation of nursing practice (Chapter 8). In order to encompass the national regulation, including the registration of healthcare professionals, each of the states and territories passed a 'model law' with the uniform title of *Health Practitioner Regulation National Law*. For example, in New South Wales it is known as the *Health Practitioner Regulation National Law (NSW)*. The provisions of the 'National Law' in place in each of the states and territories since 2009 are in identical terms and cover the registration and accreditation arrangements, complaints and professional conduct as well as health and performance arrangements of the designated healthcare professions. Nursing and midwifery are included in the scheme which commenced operation on 1 July 2010.

One of the provisions in the 'National Law' covers professional indemnity insurance. Section 129 requires that a registered health practitioner must not practise in his or her field of registration unless 'appropriate professional indemnity insurance arrangements' are in force in relation to that practitioner's professional practice. In relation to the majority of nurses and midwives who are employed in the public sector by a hospital or a designated health service (as distinct from independent contractors), the employer would have public liability and indemnity insurance in place and the individual nurse or midwife would not need to have her or his own professional indemnity insurance. In those states where recovery from a negligent employee, whether on a total indemnity or contribution basis, is prohibited (New South Wales, the Northern Territory, South Australia and Commonwealth employees) the issue does not arise. In the other states and the Australian Capital Territory, it would be expected that, in the public sector, appropriate professional indemnity insurance arrangements are in place for all healthcare practitioners. In the private sector, the situation would not be so clear-cut and nurses and midwives employed in the private sector in the Australian Capital Territory, Queensland, Tasmania, Victoria and Western Australia should ensure that they inquire about what 'professional indemnity insurance arrangements' are in place at their place of employment.

Those nurses and midwives who are practising as independent contractors must ensure that they secure appropriate professional indemnity insurance cover. Under the 'National Law' provisions, independent midwives in the course of attending homebirths have a 2-year exemption from the mandatory requirement for professional indemnity insurance — that exemption runs from 1 July 2010 and accordingly expires on 30 June 2012.

In New South Wales, in addition to the requirement for mandatory professional indemnity insurance under the *Health Practitioner Regulation National Law (NSW)*, section 19 of the *Health Care Liability Act 2001* reaffirms the mandatory requirement that medical practitioners must have professional indemnity insurance as a condition of registration and practice. Further, for medical practitioners, section 19 of that Act also states that a failure to have professional indemnity insurance as required is deemed to be unsatisfactory professional conduct.

Other healthcare professional groups covered by the provisions of the National Law in relation to the regulation of their profession are: medical practitioners, dentists and associated dental therapists, physiotherapists, pharmacists, optometrists, podiatrists, osteopaths, psychologists and chiropractors. Groups such as occupational therapists and others are scheduled to be regulated under the scheme in 2012.

The nurse or midwife as a good Samaritan

One of the concerns frequently expressed by nurses and midwives is the liability which they believe will arise if they stop and render first aid at a motor vehicle accident or other emergency. As a result of misinformation, nurses and other healthcare workers have been actively discouraged for many years from rendering such assistance, for fear of being sued. Whatever the origins of such a belief, a number of issues require clarification and certain fears need to be put to rest in relation to this matter.

As far as the common-law principles are concerned there is no legal duty to stop and render assistance in any type of emergency, and that includes a motor vehicle accident. There are some exceptions to that rule.

- There is a legal duty to help where the person requiring assistance is directly related. For example, if the family home caught fire the law would expect that, as far as is reasonably possible, the parents would attempt to rescue their children from the blaze.
- There is a legal duty to help when the person requiring assistance is under the control of another person where a duty is involved. For example, if a physical education teacher were involved in a swimming class and one of the students got into difficulties, he or she would be under a duty to do all that was reasonably possible in the circumstances to render assistance to the student.
- Specific legislation sometimes requires that a person must render assistance. For example, the most common legislative provisions apply to motor vehicle accidents where the requirement to stop and render assistance usually applies to the drivers of the motor vehicles involved in the accident. No such legal requirement applies where a person comes across the scene of the accident while driving.

With the exception of Tasmania, the legislative changes to civil liability law introduced by the states and territories following the Ipp Report incorporated provisions in relation to a person acting as a good Samaritan. For example, section 56 of the *Civil Liability Act 2002* (NSW) defines a 'good samaritan' as:

> … a person who, in good faith and without expectation of payment or other reward, comes to the assistance of a person who is apparently injured or at risk of being injured.

As provided by section 57 of that Act, a person acting as a good Samaritan does not incur any personal civil liability in relation to any act or omission when assisting a person who is injured or at risk of being injured in an emergency.

The protection from civil liability for a person acting as a good Samaritan does not apply if it is the good Samaritan's intentional or negligent act or omission that caused the injury or risk of injury in respect of which the good Samaritan first comes to the assistance of the person.

Under section 58, the protection from civil liability for a good Samaritan also does not apply if:

a) the ability of the good Samaritan to exercise reasonable care and skill was significantly impaired by reason of the good Samaritan being under the influence of alcohol or a drug voluntarily consumed (whether or not it was consumed for medication); and

b) the good Samaritan failed to exercise reasonable care and skill in connection with the act or omission; and

c) any act or omission is done or made while the person is impersonating a healthcare or emergency services worker or a police officer or is otherwise falsely representing that the person has skills or expertise in connection with the rendering of emergency assistance.

The provisions applying to good Samaritans in the respective legislation of the other states and territories are set out below.

Australian Capital Territory: See *Civil Law (Wrongs) Act 2002* s 5. The 'good samaritan' is defined in similar terms to the New South Wales definition. No civil liability will attach to a good Samaritan who acts in good faith and without recklessness. That exemption from liability will not attach if the good Samaritan is significantly impaired by alcohol or drugs.

Northern Territory: See *Personal Injuries (Liabilities and Damages) Act 2003* s 8. The 'good samaritan' is defined in similar terms to the New South Wales definition. No civil liability will attach to a good Samaritan who acts in good faith and without recklessness.

Queensland: See *Civil Liability Act 2003* s 26, which provides that no civil liability will attach where a person is rendering first aid or other assistance in an emergency and who does so in good faith and without reckless disregard for the safety of the person requiring assistance. As well, see *Law Reform Act 1995* s 16, which states that liability does not attach to a medical practitioner, nurse or 'other person' in rendering care, aid or assistance in an emergency if the act was

done in good faith and without gross negligence and without expectation of fee or reward.

South Australia: See *Civil Liability Act 1936* s 74, which provides that no civil liability will attach to a 'good samaritan' acting without expectation of reward, and in good faith and without recklessness who comes to the aid of a person in an emergency. That immunity will not operate if the good Samaritan's capacity was significantly impaired by alcohol or drugs.

Victoria: See *Wrongs Act 1958* s 31B. The definition of a 'good samaritan' is in relatively similar terms to that applying in New South Wales. As well, a good Samaritan is not liable in any civil proceedings for anything done or not done in good faith.

Western Australia: See *Civil Liability Act 2002* ss 5AB and 5AD. The 'good samaritan' is defined in similar terms to the New South Wales definition. No civil liability will attach to a good Samaritan who acts in good faith and without recklessness.

In the absence of any legislative provision in Tasmania, the standard that would apply is that of the common-law principles which is consistent with the legislative prescription in the other states and territories.

It is puzzling to know why good Samaritan provisions were considered necessary in the civil liability legislation, particularly when regard is had to the views expressed by the Ipp Committee in its report on this issue as follows:

> The Panel understands that health-care professionals have long expressed a sense of anxiety about the possibility of legal liability for negligence arising from the giving of assistance in emergency situations. However, the Panel is not aware, from its researches or from submissions received by it, of any Australian case in which a good Samaritan (a person who gives assistance in an emergency) has been sued by a person claiming that the actions of the good Samaritan were negligent. Nor are we aware of any insurance-related difficulties in this area.[113]

As the Ipp Report confirmed in the above passage, there are no reported cases in Australia of a person acting as a good Samaritan being sued by a person claiming that the actions of the good Samaritan were negligent.

Endnotes

1) Ipp Report, Parliament of Australia, *Review of the Law of Negligence, Final Report*, 2002, p viii.
2) *Donoghue v Stevenson* [1932] AC 562 at 619.
3) Ibid.
4) Ibid, at 605.
5) [1999] NSWSC 1082.
6) Ipp Report, Parliament of Australia, *Review of the Law of Negligence, Final Report*, 2002, [3.1].
7) *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 582.
8) Ibid, at 586.
9) Ibid, at 586.
10) *Sidaway v Governors of Bethlem Royal Hospital* (1985) AC 871 at 881.
11) *Rogers v Whitaker* (1992) 175 CLR 479.
12) Ibid, at 487.
13) *Halverson v Dobler; Halverson (by his tutor) v Dobler* [2006] NSWSC 1307.
14) Ibid, at [180].

15) Ibid, at [182].
16) *Rogers v Whitaker* (1992) 109 ALR 625 at 631.
17) Ibid, at 632–3.
18) *Chappel v Hart* (1998) 195 CLR 232.
19) Ibid, [96] at 276–7.
20) Ibid.
21) Ibid.
22) *Rosenberg v Percival* (2001) 205 CLR 434.
23) *Langley v Glandore Pty Ltd (in liquidation)* [1997] QCA 342 (30 October 1997); (1997) Aust Tort Reports 81-448 at 64,560.
24) Ibid, at 64-567.
25) *Lahey Estate v Craig* (1992) 123 NBR (2d) 91.
26) *Thompson Estate v Byrne* (1992) 104 Nfld and PEIR 9.
27) *Versteegh v The Nurses Board of South Australia* (1992) 60 SASR 128.
28) Now regulation 5.
29) *BT (as administratrix of the estate of the late AT) v Oei* [1999] NSWSC 1082.
30) *Sha Cheng Wang (by his tutor Ru Bo Wang) v Central Sydney Area Health Service* (SC (NSW), Hidden J, No. 17083/90, 9 June 2000, unreported).
31) Ibid, at [39].
32) Ibid, at [21].
33) Ibid, at [48]–[49].
34) Ibid, at [64]–[65].
35) Ibid, at [69].
36) Ibid, at [70]–[71], [76]–[77].
37) *McCabe v Auburn District Hospital* (SC (NSW), Grove J, No. 11551 of 1982, 31 May 1989, unreported).
38) Ibid, p 17.
39) Ibid, p 18.
40) Ibid, p 31.
41) *Norton v Argonaut Insurance Company* (1962) 144 So 2d 249 (Ct App La).
42) Ibid.
43) *Ison v Northern Rivers Area Health Service* (Industrial Relations Court of Australia, Tomlinson J, No. 44/97, 3 March 1997, unreported).
44) Ibid, at 3.
45) Ibid.
46) Ibid, at 15.
47) Ibid, at 22.
48) Ibid, at 24.
49) Ibid, at 27.
50) *Langley v Glandore Pty Ltd (in liquidation)* [1997] QCA 342 (30 October 1997); (1997) Aust Tort Reports 81-448.
51) Ibid, at 64,567.
52) Ibid, at 64,567–8.
53) Ibid, at 64,569.
54) Ibid, at 64,569.
55) *Elliott v Bickerstaff* [1999] NSWCA 453 (16 December 1999).
56) Ibid, at [8].
57) Ibid, at [101].
58) Ibid, at [102]–[103].
59) Coroner's Inquest into the death of Samara Lea Hoy, Southport Coroner's Court, Feb–Jun 2010.
60) Ibid, at 4.
61) Ibid, at 6.
62) Ibid, at 6.
63) Ibid, at 23.
64) Coroner's Inquest into the death of Timothy John Bice, Adelaide Coroner's Court, Jul–Aug 1989.
65) Ibid.
66) Ibid.
67) Ibid.
68) *McDonald v York County Hospital* (1973) 41 DLR (3d) 321.
69) *Bergen v Sturgeon General Hospital* (1984) 28 CCLT 155.
70) *Rogers v Whitaker* (1992) 109 ALR 625; *Chappel v Hart* (1998) 195 CLR 232.
71) *Chappel v Hart* (1998) 195 CLR 232 at 244.
72) *Barnett v Chelsea and Kensington Hospital* (1969) 1 QB 428.
73) *Hotson v Fitzgerald* (1985) 1 WLR 1036.
74) *Fitzgerald v Hotson* [1987] 1 All ER 210.
75) *Finch v Rogers* [2004] NSWSC 39.
76) Ibid, at [134].
77) Ibid, at [147] and [148].
78) *Tabet v Gett* [2010] HCA 12.
79) Ibid, at [152].
80) Ibid, at [111].
81) *Overseas Tankship (UK) v Morts Dock & Engineering Co* (1961) AC 388 (PC); *Overseas Tankship (UK) v Miller Steamship Co* (1967) 1 AC 617 (PC).
82) *Overseas Tankship (UK) v Miller Steamship Co* (1967) 1 AC 617 (PC) at 643–4.

83) *Compensation (Fatal Injuries) Act 1968* (ACT); *Compensation (Fatal Injuries) Act 1974* (NT); *Supreme Court Act 1995* (Qld); *Civil Liability Act 1936* (SA); *Fatal Accidents Act 1934* (Tas); *Wrongs Act 1958* (Vic); *Fatal Accidents Act 1959* (WA).

84) *Dust Diseases Tribunal Act 1989* (NSW) s 12A; *Limitation Act 1981* (NT) s 12(2)(a); *Limitation of Actions Act 1958* (Vic) s 27B(2)(a).

85) *Limitation Act 1985* (ACT) s 16B(2); *Limitation Act 1969* (NSW) ss 18A and 50C; *Limitation Act 1981* (NT) s 12(1)(b); *Limitation of Actions Act 1974* (Qld) s 11; *Limitation of Actions Act 1936* (SA) s 36; *Limitation Act 1974* (Tas) s 5(1); *Limitations of Actions Act 1958* (Vic) s 5(1AA); *Limitation Act 2005* (WA) s 13(1).

86) *Civil Law (Wrongs) Act 2002* (ACT) s 102; *Law Reform (Miscellaneous Provisions) Act 1965* (NSW) s 9(1) and *Civil Liability Act 2002* (NSW) s 5R; *Law Reform (Miscellaneous Provisions) Act 1956* (NT) s 16(1); *Law Reform Act 1995* (Qld) s 10(1) and *Civil Liability Act 2003* (Qld) s 23; *Law Reform (Contributory Negligence and Apportionment of Liability) Act 2001* (SA) s 7 and *Civil Liability Act 1936* (SA) s 5K; *Wrongs Act 1954* (Tas) s 4(1) and *Civil Liability Act 2002* (Tas) s 23; *Wrongs Act 1958* (Vic) ss 26(1) and 44; *Law Reform (Contributory Negligence and Tortfeasors' Contribution) Act 1947* (WA) s 4(1) and *Civil Liability Act 2002* (WA) s 5K.

87) *Zuijs v Wirth Bros Pty Ltd* (1955) 93 CLR 561.

88) *Hollis v Vabu Pty Ltd* (2001) 207 CLR 21.

89) Ibid, at 41.

90) Ibid, at 42–5.

91) Fleming J G, *The Law of Torts*, 9th ed, Law Book Company, Sydney, 1998, p 416.

92) *Roe v Minister for Health* (1954) 2 QB 66.

93) Ibid, p 82.

94) *Albrighton v Royal Prince Alfred Hospital* (1980) 2 NSWLR 542.

95) *Albrighton v Royal Prince Alfred Hospital* (1979) 2 NSWLR 165 at 166.

96) *Albrighton v Royal Prince Alfred Hospital* (1980) 2 NSWLR 542 at 543.

97) *Ellis v Wallsend District Hospital* (1989) 17 NSWLR 553.

98) Ibid, at 600.

99) Ibid, Samuels JA at 598–9.

100) Ibid, Kirby P at 565–6.

101) Ibid, Samuels JA at 604–5.

102) Ibid, Kirby P at 568–9.

103) Ibid, Kirby P at 569.

104) Fleming, op. cit., p 421.

105) *Chaplin v Dunstan* (1938) SASR 245.

106) *Storey v Ashton* (1986) IR 4 QB 476.

107) *Lister v Romford Ice and Cold Storage Co Ltd* (1957) AC 555.

108) Extract from the decision of *McGrath v Fairfield Municipal Council* (1985) 59 ALR 18 at 19 in referring to the decision in *Lister v Romford Ice and Cold Storage Co Ltd* (1957) AC 555.

109) *Insurance Contracts Act 1984* (Cth) s 66; *Employees Liability Act 1991* (NSW) ss 3 and 5; *Law Reform (Miscellaneous Provisions) Act 1984* (NT) s 22A; *Civil Liability Act 1936* (SA) s 59.

110) *Compensation and Professional Indemnity in Healthcare: Final Report*, Australian Government Publishing Service, Canberra, November 1995.

111) Ibid, recommendation 128.

112) Ibid, recommendation 132.

113) Ipp Report, Parliament of Australia, *Review of the Law of Negligence, Final Report*, 2002, [7]–[21].

This page intentionally left blank

Chapter 4

Consent to treatment

(Including the right to withhold consent, end of life planning and not for resuscitation orders, and the right to detain and restrain patients without their consent)

Why is consent important?

The area of law studied in this chapter is an area of civil law relating to a trio of civil wrongs or torts which fall under the collective heading of trespass to the person. These torts, which are divided into assault, battery and false imprisonment, exist to protect people's 'personal space'. However, for nurses and midwives, this topic is often referred to as 'consent' because the consensual aspect of the law is more readily identified as relevant to people working in healthcare. In fact, to put consent to treatment into its proper legal perspective, the consent is in reality a defence to actions in assault, battery or false imprisonment, which explains why it becomes so important to healthcare professionals in their daily work.

The principles covering this area of the law are based on common-law principles, which have been extended by individual state or territory legislation in some areas, particularly in relation to children.

Assault and battery

Assault can also be, and is most often contemplated as, a criminal offence. However, as far as staff working in healthcare are concerned, assault as a crime does not have general application. The criminal offence of assault would not only consist of the application of force to another person without his or her consent, but would include the actual intent to cause harm to the person assaulted, or a very high degree of reckless indifference to the probability of harm occurring to the person assaulted. It is fortunately rare for such an intention or attitude to prevail among healthcare personnel. Where it does, it would undoubtedly become a professional disciplinary matter as well as a criminal matter. Some disciplinary cases involving nurses who did intentionally harm their patients is discussed briefly in Chapter 8.

As far as the civil law is concerned, there is a technical distinction to be made between assault and battery, although in common parlance no such distinction is made and the word assault is often (inaccurately) used to embrace both actions. To explain the technical distinction, an assault can be committed merely by putting a person in fear for his or her physical wellbeing; for example, shaking a fist in front

of a person's face and threatening to punch the person could well constitute an assault. If such a threat were to be carried out, the actual application of the blow to the person's body would constitute the technical offence of battery. The offence of battery, it was famously said, 'exists to keep people free from "unconsented-to touchings"'.[1] There is current debate about whether this notion of consent, as solely the protection of 'bodily integrity' identified by the English and Australian courts, as being the purpose of this branch of the law goes far enough, or whether the law actually goes further and is concerned with 'rights and duties and control of destiny'.[2]

Regardless of its limited or wider application, it becomes clear from the above why the defence of consent is so important to healthcare professionals, who are often required to 'touch' people in what would normally be extremely private and personal ways in the course of examination, care and treatment. Often the circumstances in which they are required to perform these 'touchings' can also be quite unusual, such as in emergency departments or operating theatres, where the patient's mental state may be altered, intentionally or otherwise. Any treatment given to a patient without the patient's consent, or the consent of a person entitled to give such consent on behalf of the patient, constitutes a battery for which the patient is entitled to be compensated by an award of damages. It is a well-established legal principle, which the courts will uphold, that 'every human being of adult years and sound mind has a right to determine what shall be done with his own body'.[3] There are some exceptions to that statement, which have largely been created by statute. Some of these are dealt with in this chapter and others in Chapter 11.

Relevance of consent generally

Consent as a defence in law has relevance far beyond the area of treatment to patients in hospitals or health centres. For example, in the criminal law, the charge of aggravated sexual assault essentially comprises two elements:

1) that sexual intercourse took place; and
2) that intercourse was without the complainant's consent.

Clearly, it is the absence of consent which renders an otherwise legitimate act a crime.

Consent to disclosure of specified private information negates the possibility of an action for breach of confidentiality in relation to that information. Consent as a defence also arises for consideration in relation to civil negligence, where it is otherwise known as the *defence of volenti*, explained in Chapter 3. Although such a defence has limited application in hospitals and health centres, it is another example of the application of consent as a defence in a variety of legal situations, both criminal and civil.

Negligence must be distinguished

Any consideration of the absence or otherwise of consent to treatment must not be confused with negligence. Negligence and assault and battery are two distinct and separate civil wrongs and it is not necessary for a negligent act to precede a battery

in order for a civil action alleging battery to succeed. As far as any treatment given to a patient is concerned, it is quite possible that such treatment was competently given, that the patient suffered no harm and recovered completely, yet the patient can still succeed in an action in battery if he or she has not consented to the treatment given. The fact that the specific type of 'touching' occurred without the patient's consent means that a battery has occurred.

The main reason why patients undergo any form of medical treatment is their belief that their condition will be improved or at least palliated by the treatment given. Normally, if their condition is improved, most patients are happy to let the situation rest even if they did not know the precise details of what had happened to them or even if their treatment was slightly different to that which they had anticipated. An exception to this is where treatment may be given in disregard of a person's moral or religious convictions, and even if the outcome were successful, the patient may still feel deeply aggrieved.[4] In the Canadian case of *Malette v Shulman*, where a Jehovah's Witness was given a life-saving blood transfusion against her express wishes, she successfully sued in battery, with Robins JA making the observation that:

> The patient manifestly made the decision on the basis of her religious convictions. It is not for the doctor to second-guess the reasonableness of the decision or to pass judgement on the religious principles which motivated it.[5]

Mrs Malette was seriously injured in a motor vehicle accident in which her husband was killed. She was taken by ambulance to hospital. She had severe head and facial injuries and was bleeding profusely. She was initially transfused with intravenous glucose and Ringers Lactate. On admission a nurse discovered a card in Mrs Malette's purse, which identified her as a Jehovah's Witness, and in which she requested, on the basis of her religious convictions, that she be given no blood transfusions under any circumstances. The nurse advised Dr Shulman, the doctor on duty, of the existence of the card and its contents.

Shortly after admission Mrs Malette's condition deteriorated sharply and she became critically ill. Dr Shulman decided that a blood transfusion was necessary to replace Mrs Malette's lost blood and preserve her life and health. He personally administered blood transfusions to her despite the directions on the card found in her purse and a request by Mrs Malette's daughter, who had subsequently arrived at the hospital, that the transfusions be discontinued. When Mrs Malette recovered from her injuries she sued Dr Shulman for battery on the basis that she had specifically withheld her consent to blood transfusions as evidenced by the card in her purse and, in treating her contrary to that express request, Dr Shulman had committed a battery. Mrs Malette's action against Dr Shulman was not compromised by the fact that Dr Shulman had not been negligent in any way. Indeed as the judgment states:

> It is important to note here that Dr Shulman was not found liable for any negligence in his treatment of Mrs Malette: he had acted promptly and professionally and was well motivated throughout and his management of

> the case had been carried out in a competent, careful and conscientious manner in accordance with the requisite standard of care. His decision to administer blood in the circumstances confronting him was found to be an honest exercise of his professional judgment which did not delay Mrs Malette's recovery, endanger her life or cause her any bodily harm. Indeed, the doctor's treatment of Mrs Malette may well have been responsible for saving her life.[6]

Notwithstanding this somewhat unusual situation, as a general rule, it is when something goes wrong and patients suffer damage as a result of their treatment that they start to seek further explanations and information. On some occasions, the care or treatment may have gone wrong because a person has not exercised adequate care and an action in negligence may be a possible outcome. On other occasions all the most prudent precautions and competence will still not prevent unforeseen problems arising. Nevertheless, when something does go wrong, invariably the patient will want to know what happened, why, who did what and when, or perhaps whether anyone failed to do something. The process for managing adverse events and disclosing their occurrence to patients is discussed in Chapter 7, specifically in relation to the practice of 'open disclosure'. Depending on the facts and circumstances and, more often than not, influenced by the degree of damage that has occurred and the way in which the adverse event was managed, the patient may seek legal advice about the appropriateness of making a complaint and/or suing the doctor, hospital and any other parties the patient feels may have been responsible for the damage that has occurred. However, Piper and Iedema point out that:

> … there are no signs of spikes in medical negligence litigation, health care complaints or medical board actions in Australia over the last five years as interest in and enactment of Open Disclosure has increased.[7]

If the patient chooses to make a complaint, this may be done locally to the hospital or through the relevant healthcare complaints body or registration authority. In such situations the patient is often concerned that the same mistake does not happen again, and the purpose is often to improve patient safety, rather than to seek financial redress. Complaints of this nature are discussed in detail in Chapter 8.

If, on the other hand, the patient decides to take legal action, the legal action that may be contemplated will generally revolve around three potential considerations:

1) professional negligence, either by act or omission;
2) assault and battery in the absence of a valid consent; and/or
3) breach of contract (where a contractual relationship exists between the patient and the provider of treatment).

The first two potential causes of action, negligence and battery, often overlap, and this can confuse the layperson. This overlap of actions is often described (erroneously in Australia) as *informed consent*. For legal purposes, as is demonstrated above, there are two distinct areas of law in play here. The question of adequately

informing a patient in 'broad terms of the nature of the procedure which is intended' is critical to the issue of obtaining a valid consent as a defence to an action in battery.[8] However, the failure of a medical practitioner to inform a patient adequately about the treatment he or she is to undergo, particularly the material risks involved and likely outcome of any proposed treatment, can and has been determined by the courts to be negligence.[9] Such a failure will, more often than not, be deemed to be a breach of the doctor's duty of disclosure, as part of his or her duty of care to the patient. That important distinction, together with the relevant cases and the views expressed by the courts, is set out in Chapter 3.

Remember that, in any allegation of negligence, the patient must prove all the necessary elements, including the fact that he or she has suffered some form of recognisable damage. As far as any action in battery is concerned, the patient does not have to prove damage, but rather an intentional touching and the absence of consent to the treatment given. The amount of compensation awarded by a court in such a situation may be nominal when compared to the compensation awarded if the patient were damaged and could prove negligence. Nevertheless, it is possible for a patient to bring an action seeking compensation for battery in the absence of any negligence on the part of the person concerned, an absence of any physical harm to the person bringing the action and solely on the basis that consent was not given to the type of touching which occurred. The case of *Malette v Shulman* discussed above made precisely this point.[10] Although the decisions of Canadian courts are not binding on Australian courts, they would be considered to be persuasive precedent. The case is particularly interesting because it demonstrates the distinction between an action in negligence and battery and at the same time it reinforces the right of a person to withhold consent to treatment — in this case, a blood transfusion.

Despite the above comments the court upheld Mrs Malette's claim against Dr Shulman on the basis that he had violated Mrs Malette's 'rights over her own body by acting contrary to the Jehovah's Witness card and administering blood transfusions that were not authorised'.[11] The court awarded Mrs Malette $20 000 damages but declined to make any award of costs; that is, Mrs Malette would have had to pay her own legal costs out of the damages awarded. Compared with the amount of damages awarded by courts today for negligence actions, Mrs Malette's damages of $20 000 for battery would certainly be considered nominal, particularly as she had to pay her own legal costs. In a number of more recent cases involving blood transfusions and Jehovah's Witnesses, not all the decisions are as clear-cut as this one.[12] However, *Malette v Shulman* does provide a clear example of what the tort of battery is intended to do, which is to uphold the right of individuals to control what happens to their own body.

What information is available to help professionals and patients?

Clearly these matters are extremely complex and there are many useful documents available to assist healthcare professionals and consumers alike both to understand the law and to provide the best available information and practices. For healthcare professionals, there is a range of useful information; for example, the National

Health and Medical Research Council (NHMRC) publication, *General Guidelines for Medical Practitioners on Providing Information to Patients*.[13] The NHMRC has also produced a companion document, *Communicating with Patients: Advice for Medical Practitioners*.[14] Although these documents inexplicably only refer to the information and communication practices of medical practitioners, they will be of equal value for nurses and allied healthcare practitioners who provide information about treatment and care for patients. State and territory governments also produce comprehensive policy documents relating to consent for medical treatment. Links to two state policy examples (WA, 2010 and NSW, 2005) are provided in the endnotes; each is extremely comprehensive and a valuable resource for any healthcare professional who wishes to understand not only the law but also how the law operates in practice.[15] In addition, there are many useful consumer information documents — some developed by government and others developed by consumer organisations, such as the Fitzroy Legal Service Inc. in Victoria, which provides accessible information about the law and what people are entitled to expect. Consumer organisations such as the Consumer Health Forum also give sound advice and provide lists of questions to ask.[16]

How may consent be given?

It is helpful to remember that the word 'consent' comes from the Latin *consensere*, meaning 'to agree'. Thus, consent is an agreement between two parties, and requires a level of common understanding. When considering the question of consent, it is generally stated that it is necessary for a patient to give a *valid consent*. The use of the term 'valid consent' simply denotes the necessity to ensure that any consent given comprises certain elements; otherwise the consent will be invalid. The elements that comprise a valid consent apply regardless of the way in which consent is given. Consent can be given in the following ways:

- impliedly;
- expressly — verbally;
- expressly — in writing.

Implied consent to treatment can be given in a variety of ways and is most often used as the method of giving consent to a simple procedure of common knowledge. For example, a nurse might request a patient to hold out his or her arm to have their blood pressure taken, or to roll over onto their back preparatory to being lifted out of bed, and the patient's compliance with such a request would normally imply consent to that process or intervention. Even though a patient may appear to be implying consent for the intended procedure by their actions, it is good practice to explain fully to the patient what you are going to do, regardless of any behaviour that you may take to imply consent. In addition, the element of common knowledge means that it is not sufficient to make the claim that a person has given consent to a treatment 'simply by turning up at the hospital'. In the 1984 deep sleep therapy (DST) case of *Hart v Herron*, the Supreme Court held that turning up at the hospital was not sufficient to imply consent for treatment, and the defendant was found to be liable in battery for administering the DST.[17] DST does not constitute a simple

procedure of common knowledge. Quite clearly it is not possible to consent to a procedure about which you have neither knowledge nor understanding, as a person cannot agree to that which they have not contemplated.

Verbal consent is probably the most common form of consent occurring in relation to simple procedures both in hospitals and health centres. Both verbal and written consents are often described as express consent; that is, the person has expressly indicated that they consent to the procedure or intervention, rather than the health-care practitioner having to make assumptions by implication. For an example of an express verbal consent, in both hospitals and the community in the great majority of cases, a conversation takes place between the doctor and the patient concerning the patient's condition and/or medical history. The conversation is usually accompanied by a medical examination and/or some preliminary tests. At the conclusion of the conversation the medical practitioner will advise the patient about his or her diagnosed or potential condition, describe the recommended treatment for the patient, what medication should be taken and/or whether admission to hospital or other treatment is required. Almost inevitably the patient accepts the doctor's advice and agrees (that is, consents) to undergo the treatment suggested by the doctor. What is happening, of course, is that the patient is verbally consenting to treatment, often in the form of medications. No form has been signed, nor need it be when consent is given in such circumstances. Similarly, a nurse who is going to undertake a procedure, such as a complex wound dressing, will inevitably explain what they are going to do, describe how they are going to do it and elicit the patient's assistance should that be necessary. The patient will usually verbally agree to the process, may seek clarification about anything they are unclear about and will then provide whatever assistance is necessary to enable the nurse to carry out the dressing.

A *consent in writing*, in the form of either a standard or specialised written consent form, is generally nothing more than documentary evidence of what has already been consented to verbally by the patient. In many ways the function served by a written consent form parallels the function of a contract made in writing. It is quite possible to create a legally binding contract between two parties by verbal agreement without recourse to a document, as long as the elements of a simple contract exist. In general terms, therefore, the main function that a written consent fulfils is to express in writing what has been verbally agreed to between the parties. There is no general legal principle that states that consent forms must exist and be signed before a patient can be treated, although there are now a number of situations where either law or policy requires consent in writing. For example, the Western Australian (WA) Department of Health Office of Safety and Quality in Health Care, in its *Consent to Treatment Policy for the Western Australian Health System*, requires written consent in the following situations:

- surgical, medical, radiology, oncology and endoscopy treatments or procedures requiring general, regional or local anaesthesia, or intravenous sedation;
- invasive treatments or procedures where there are known significant risks or complications;
- sterilisation of a minor and the application of electroconvulsive therapy (special circumstances apply);

- administration of medications with known high-risk complications, or new unusual medications which may have risks;
- drugs administered under the Special Access Scheme;
- participation in clinical trials and medical research.[18]

The critical element that a completed written consent form provides, on the face of it, is documentary evidence that consent was given, should a dispute arise over that point. Having said that, a written consent in no way guarantees that the consent given is a valid one — that is another issue completely. It is true to say that a consent form is only as good or as valid as the quality of the consent or agreement that has been made and that it represents. It is the validity of the consent that goes to the heart of the procedural requirements, and not the signing of a piece of paper.

What are the elements of a valid consent?

The validity of any consent, however given, will only be satisfied if the three elements that constitute a valid consent are present. Those elements are:

1) that any consent given is freely and voluntarily given;
2) that any consent given is properly informed; and
3) that the person giving consent has the legal capacity to give it.

We will now examine each of these in turn.

Any consent given is freely and voluntarily given

This means that any consent given by a patient must be given without any fraud, duress or coercion being applied by the medical practitioner or other member of staff in order to obtain the patient's consent. As a general rule, medical and nursing staff do not deliberately seek to apply fraudulent or coercive measures on patients to obtain their consent, but can do so unwittingly in a variety of ways. For example:

- if a healthcare practitioner advises a patient that he or she must have a particular form of treatment or else he or she will be discharged;
- the authoritative role of a healthcare practitioner may introduce an element of coercion into the consent procedure on the basis of 'I know what's best for you'.

If it can be established that any coercion or duress was brought to bear on a patient in order to obtain his or her consent, that consent will be invalid.

Sadly, on occasions nurses have been involved in deceptions to obtain consent, as shown in the Royal Commission into Deep Sleep Therapy, which investigated the practices of a psychiatrist and his colleagues who admitted mentally ill patients to a private hospital (Chelmsford) and gave them the 'special treatment' of barbiturate-induced coma and sometimes adjuvant electroconvulsive therapy. Over the ensuing 16 years until 1979, at least 24 people died as a direct result of the DST. This excerpt from the testimony of one nurse gives an example of how deception was used to implement the DST.

> Some who did know, if they refused to sign the consent form, then the instruction was that you gave them some medication to quieten them down; that's what you would say, 'I'll give you this little injection now, it will calm you down. You will feel a lot better after it'. But of course that little injection was Sodium Amytal and I think some Valium as well and then of course they were off on the sedation.[19]

Whilst no action was taken against any nurses as a result of the events at Chelmsford, this excerpt provides a clear example of how deception might be employed to obtain consent to treatment. Such behaviour is clearly not acceptable and would negate consent.

The patient is informed 'in broad terms of the nature of the procedure which is intended'[20]

This element probably gives the greatest concern to nursing staff, largely because of the problems that arise in relation to written consent forms. From a strictly legal perspective the term 'informed consent', that can be traced to early American decisions,[21] is no longer considered to be appropriate, confusing as it does the requirement for consent in defence to actions in battery and the requirement to give information about material risks, the absence of which forms one of the elements of an action in negligence. However, in the practicality of explaining a procedure to a patient there is an alignment of the two processes, as people need not only to be informed in broad terms (thus providing a defence against an action in battery) but also to be informed about the material risks (thus providing a defence against a potential action in negligence).

Perhaps a helpful way to think about the issue is to consider the concept of giving information (and informed consent) in general, everyday terms. On a day-to-day basis people make decisions on a whole variety of issues which affect their lives — whether it be to buy a house or a new car, take an overseas holiday, take out insurance or change jobs. In making decisions on such major issues, people obtain relevant information which will help them to decide whether or not to go ahead with a particular proposal; for example, cost, finance available, repayments, access to public transport and schools, career opportunities and so on. A person will then assess the various alternatives available before coming to a final decision on the matter. The gathering together of the information needed to arrive at the most appropriate decision constitutes the informed element of the consent process. It is much the same situation when considering whether or not to consent to a particular medical treatment. Obviously the consequences of making a decision about healthcare are far more serious than deciding whether or not to buy a new car, thereby only increasing the need for information and care. Nevertheless, the principle is the same.

In Australia two questions arise from the fact that information must be given to a patient when he or she is being asked to consent to a treatment:

1) How much information does the patient require to make a decision to consent to treatment?
2) Who is responsible for giving sufficient information to a patient?

Let us consider each in some detail below.

HOW MUCH INFORMATION DOES THE PATIENT REQUIRE TO MAKE A DECISION TO CONSENT TO TREATMENT?

At this point it is necessary to restate that, invariably, when this issue is considered it is done within the context of negligence, having regard to the perceived duty of the doctor to inform the patient adequately about the material risks inherent in any proposed treatment, and readers should refer to the cases on this issue in Chapter 3. That is not to suggest that an action in battery cannot or should not be pursued. It simply reflects the views expressed by the courts in Australia and elsewhere, particularly in England, on this issue. Indeed the decision of the High Court of Australia in *Rogers v Whitaker* makes it quite clear that actions against medical practitioners alleging inadequacy of information about a proposed treatment should properly be considered as part of the medical practitioner's duty of care within the context of an action in negligence.[22] The facts of *Rogers v Whitaker* are set out in Chapter 3, and should be referred to. The facts reveal that Mrs Whitaker received precisely the treatment to which she had consented, thus there could be no successful action in battery. In unanimously dismissing Dr Rogers' appeal the High Court made the following comment on the issue of informed consent:

> In this context nothing is to be gained by reiterating the expressions used in American authorities such as 'the patient's right of self-determination' or even the oft-used and somewhat amorphous phrase 'informed consent'. The right of self-determination is an expression which is, perhaps, suitable to cases where the issue is whether a person has agreed to the general surgical procedure or treatment, but is of little assistance in the balancing process that is involved in the determination of whether there has been a breach of the duty of disclosure. Likewise, the phrase 'informed consent' is apt to mislead as it suggests a test of the validity of the patient's consent. Moreover consent is relevant to actions framed in trespass, not in negligence. Anglo-Australian law has rightly taken the view that an allegation that the risks inherent in a medical procedure have not been disclosed to the patient can only be found an action of negligence and not in trespass; *the consent necessary to negative the offence of battery is satisfied by the patient being advised in broad terms of the nature of the procedure to be performed*.[23] [emphasis added]

In 2004 the NHMRC updated its *General Guidelines for Medical Practitioners on Providing Information to Patients*.[24] The advice on the content of the information is set out in Box 4.1.

In addition to the advice about the content of the information to be presented when obtaining consent to treatment, the document also provides valuable advice on presenting and withholding information, which is set out in Box 4.2.

Having regard to all of the above, the issue of how much information a person requires to decide to consent to treatment can be summarised as follows:

- the information element of a valid consent is the gathering together of the information needed to allow a patient to arrive at a decision that the patient believes is in his or her own best interests;

BOX 4.1
CONTENT OF INFORMATION TO BE GIVEN WHEN OBTAINING CONSENT TO TREATMENT

Information to be given

Doctors should normally discuss the following information with their patients:

- the possible or likely nature of the illness or disease;
- the proposed approach to investigation, diagnosis and treatment:
  - what the proposed approach entails
  - the expected benefits
  - common side effects and material risks of any intervention
  - whether the intervention is conventional or experimental
  - who will undertake the intervention
- other options for investigation, diagnosis and treatment;
- the degree of uncertainty of any diagnosis arrived at;
- the degree of uncertainty about the therapeutic outcome;
- the likely consequences of not choosing the proposed diagnostic procedure or treatment, or of not having any procedure or treatment at all;
- any significant long-term physical, emotional, mental, social, sexual, or other outcome which may be associated with a proposed intervention;
- the time involved; and
- the costs involved, including out-of-pocket costs.

1. Informing patients of risks

Doctors should give information about the risks of any intervention, especially those that are likely to influence the patient's decisions. Known risks should be disclosed when an adverse outcome is common even though the detriment is slight, or when an adverse outcome is severe even though its occurrence is rare. A doctor's judgment about how to convey risks will be influenced by:

- the seriousness of the patient's condition; for example, the manner of giving information might need to be modified if the patient were too ill or badly injured to digest a detailed explanation;
- the nature of the intervention; for example, whether it is complex or straightforward, or whether it is necessary or purely discretionary. Complex interventions require more information, as do interventions where the patient has no illness;
- the likelihood of harm and the degree of possible harm; more information is required the greater the risk of harm and the more serious it is likely to be;
- the questions the patient asks; when giving information, doctors should encourage the patient to ask questions and should answer them as fully as possible. Such questions will help the doctor to find out what is important to the patient;
- the patient's temperament, attitude and level of understanding; every patient is entitled to information, but these characteristics may provide guidance to the form it takes; and
- current accepted medical practice.

BOX 4.2
ADVICE ON PRESENTING AND WITHHOLDING INFORMATION

2. Presenting information

The way the doctor gives information should help a patient understand the illness, management options, and the reasons for any intervention. It may sometimes be helpful to convey information in more than one session. The doctor should:

- communicate information and opinions in a form the patient should be able to understand;
- allow the patient sufficient time to make a decision. The patient should be encouraged to reflect on opinions, ask more questions, consult with the family, a friend or advisor. The patient should be assisted in seeking other medical opinions where this is requested;
- repeat key information to help the patient understand and remember it;
- give written information or use diagrams, where appropriate, in addition to talking to the patient;
- pay careful attention to the patient's responses to help identify what has or has not been understood; and
- use a competent interpreter when the patient is not fluent in English.

3. Withholding information

Information should be withheld in very limited circumstances only:

- if the doctor judges on reasonable grounds that the patient's physical or mental health might be seriously harmed by the information; or
- if the patient expressly directs the doctor to make the decisions, and does not want the offered information. Even in this case, the doctor should give the patient basic information about the illness and the proposed intervention.

- if there were to be any statement of general legal propositions applicable in Australia, it would be that, in obtaining a valid consent, a patient must be given sufficient information to be able to understand the nature and consequences of the proposed treatment; and
- failure to advise and inform a patient properly about the nature and consequences of the proposed treatment as well as its material risks would, in most instances, amount to a breach of the doctor's duty of care, which could, should damage ensue, make the doctor liable in negligence, quite apart from any action in battery.

WHO IS RESPONSIBLE FOR GIVING SUFFICIENT INFORMATION TO A PATIENT?

At first glance there would be no doubt that the responsibility for giving the patient sufficient information to enable him or her to make an informed decision rests

with the primary treating healthcare practitioner. In some situations where no doctor is involved, the responsibility would rest with the person in charge of the case. For example, in the case of a homebirth conducted by a homebirth midwife with no obstetrician involved, the responsibility for giving the patient sufficient and relevant information rests with the midwife. Likewise, where the treating healthcare practitioner was a nurse practitioner, the primary responsibility would rest with the nurse practitioner. This situation has been recognised in policy. For example, the New South Wales Policy Directive PD2005_406 states that:

> … authorised nurse practitioners may initiate medications, order diagnostic tests and make referrals only when they are operating under guidelines approved by the Director-General. Nurse practitioners have the same obligations as do medical practitioners, when obtaining consent for the procedures which they are authorised to perform.[25]

Until recently, the usual situation encountered in hospitals and health centres would be that the treating doctor would carry responsibility for informing the patient about the treatment he or she has consented to undergo. Two questions are regularly raised by nursing (and sometimes midwifery) staff in relation to this:

1) What is the scope of responsibility for a nurse (or other healthcare employee) who is asked to obtain a patient's signature for a consent form?
2) What are the professional responsibilities of nurses and midwives to inform patients of aspects of their treatment if they believe they have not been fully explained by the treating healthcare practitioner? Alternatively, what are the nurses' and midwives' professional responsibilities when a patient asks them for advice about the appropriateness of the treatment he or she is having?

This second group of professional dilemmas often arises in relation to treatments which patients undergo on the advice of their treating doctor in terminal illnesses; for example, chemotherapy, radiotherapy and radical surgery.

Both of these issues will now be examined.

Written consent forms

For many years hospitals insisted that nurses (or other administrative personnel) were responsible for obtaining a patient's signature on consent forms. It is pleasing to note that key policy documents have now placed the responsibility primarily where it rightfully belongs — with the medical officer or other treating practitioner concerned. The policy allows for delegation, but not abrogation, of responsibility. The New South Wales Ministry of Health policy on consent to treatment has this to say:

> Where a practitioner recommends or advises that a patient undergo an operation, procedure or treatment, they will be responsible for ensuring they provide sufficient, appropriate and relevant information and advice to enable the patient to make their own decision to undergo the operation, procedure or treatment. Once again, this does not mean that they cannot have another person undertake that task, although they may be held responsible in some circumstances if this is not done properly.[26]

Legally any person over the age of 18 years and of sound mind may witness a patient's signature on a consent form. This argument is the one most often raised by medical practitioners, who state that they should not be required to witness a patient's signature on a consent form because it can legally be done by any member of staff. This comment is in fact correct in this situation: there is no requirement for any specific person to witness a signature. However, it does nothing to address the concerns often raised by nursing and midwifery staff about witnessing the consent form, as the signing of the form often brings about a plethora of questions heretofore unasked. This is where it is important to remember that, if the patient has agreed to come into hospital for treatment, it is usually on the basis of the advice of the medical practitioner. Therefore, as a matter of commonsense and good practice, it is the medical practitioner who should witness the patient's written consent to that treatment, particularly when the procedure is an elective procedure.

In hospitals where such a task is still designated to the nursing staff (or indeed administrative staff) the only role that the staff member plays in obtaining the patient's signature is to witness that signature. Witnessing a patient's signature in no way imposes on the staff member a responsibility for informing the patient of the nature and extent of the procedure to which the patient is consenting. If a nurse or midwife is required to ask a patient to sign a consent form, they should observe the following steps. (See also Box 4.3 for the status of written consent forms.)

- Always ensure that the consent form is completely filled in. A patient should never be asked to sign a blank consent form.
- If a patient wishes to alter the consent form in any way by adding or crossing out words, then the nurse or midwife must advise the treating practitioner as soon as possible.
- If a patient starts to ask questions concerning the nature and extent of the procedure to which the patient is consenting, the nurse or midwife should offer to ask the patient's treating doctor to come and talk to the patient. In contacting the treating practitioner, the nurse or midwife should make a

BOX 4.3
STATUS OF WRITTEN CONSENT FORMS

Finally, nurses and midwives should remember that a signed written consent form in no way guarantees that the consent is a valid one. To determine validity, it is necessary to ensure that all the principles of a valid consent were present when the agreement was reached as to the nature and extent of the treatment to be undergone. The mere mechanical signing of a standard form of consent at the request of a member of the hospital staff is, by itself, of limited value. What is important is that the patient has been given adequate information and advice so that there is a genuine understanding of the nature of the treatment and the significant risks inherent in it, and has agreed to the treatment on that basis.

relevant entry in the patient's records, as well as noting the practitioner's response to the request.

- If a patient refuses to sign a consent form, the treating practitioner must be advised and a relevant entry made in the patient's record. In a hospital, the appropriate administrative personnel should also be advised.

The professional responsibility to inform

Nursing and midwifery staff do have a professional responsibility to educate patients and to provide secondary information about a particular treatment, once the course of treatment has been agreed upon. Nursing staff are often questioned by patients about the treatment they are undergoing. They are the most frequent source of contact and conversation in a hospital and patients often relate readily to the nursing staff for that reason. It is completely appropriate for nursing staff to provide the best advice and information available and to answer patients' questions honestly and helpfully in relation to the agreed treatment, and significant advantages are known to attach to the provision of pre-operative information.[27] However, there have been occasions where nurses have found themselves in the difficult position of caring for a patient who, they believe, has not received sufficient information concerning the particular treatment he or she is undergoing or the alternative courses of treatment which may be available to the patient. The most frequent problem has been in relation to the treatment of patients for various types of cancer, which quite often involves the administration of large doses of cytotoxic drugs and radiotherapy. This type of treatment often results in physically and mentally distressing side effects for the patient which, if the patient's life expectancy is quite limited, can cause many healthcare professionals to question the efficacy of the treatment. In such a situation the nurse must carefully assess his or her professional position before seeking to intrude on the patient–doctor relationship.

There have been occasions where nursing or midwifery staff have become concerned and openly critical about the standard of care being practised by a nursing or medical colleague. The problem becomes particularly difficult when the criticism is directed at a medical practitioner who the nursing or midwifery staff believe is giving unsafe and/or inappropriate medical care to a patient.

If a member of the nursing or midwifery staff is genuinely concerned about the standard of care being delivered by a professional colleague, that concern should first, as a matter of courtesy and commonsense, be dealt with by discussing it directly with the professional colleague involved. If those direct discussions do not resolve the problem it should then be expressed formally to the appropriate administrative personnel. Sometimes, a nurse or midwife may feel unable to initiate such a conversation, and if they are genuinely concerned about a matter of safety, it is imperative that they discuss the matter with more senior professional staff who could take the matter up on their behalf. However, it is important that the concerned person has clear information and evidence to support their concern. It may be that the matter can be resolved at that level by discussions between the parties concerned.

If such an approach is unsuccessful and the criticisms expressed are valid, then as of 1 July 2010, there is a mandatory requirement under the new *Health Practitioner Regulation National Law Act 2009* (Qld) (discussed in more detail in Chapter

8) to report 'notifiable conduct' by a colleague to their relevant professional registration board. Notifiable conduct is defined under the Act as meaning that the registered healthcare practitioner has:

- practised the practitioner's profession while intoxicated by alcohol or drugs; or
- engaged in sexual misconduct in connection with the practice of the practitioner's profession; or
- placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or
- placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.[28]

In doing so, criticisms that form the subject of the complaint should be supported by objective and factual documentation. At no time should such professional criticisms become the subject of general gossip, particularly outside the hospital where some people may be only too ready to believe such criticisms. If this happens, then that person's professional reputation may be irreparably damaged and the person would have legitimate resort to an action in defamation.

In recent years, there has been a greater emphasis on a systems approach to problems and errors in healthcare. Human beings make mistakes[29] and healthcare professionals are no exception.[30] The aviation industry has already undertaken a considerable amount of work and has developed the concept of crew resource management, which creates the imperative for each member of the aviation team to speak out forcefully if he or she believes there is any problem.[31] This work is being replicated in the healthcare sector and there is a prevailing view that all healthcare professionals have a responsibility to speak up (appropriately, as discussed above) to avoid adverse incidents occurring and to report adverse events so that analysis can occur and preventative strategies can be implemented. A strategy for helping those staff who may feel unable to speak out about healthcare concerns is known as *graded assertiveness*. Curtis et al. (2011) provide an example of escalation of expressions of concern, set out in Figure 4.1.[32]

THERAPEUTIC PRIVILEGE

In some limited situations the law will recognise that, although there may well be a general duty to disclose what is reasonable and necessary in the circumstances, an exception can arise. The usual situation is where the treating doctor elects to use what is termed *therapeutic privilege*; that is, the doctor chooses not to disclose information to a patient that he or she believes would be detrimental to the patient's best interests, generally for mental health reasons.

As the general guidelines issued by the NHMRC[33] and set out in Box 4.2 state, that significant information should not be withheld except in the very limited circumstances referred to in the guidelines, namely:

- if the doctor judges on reasonable grounds that the patient's physical or mental health might be seriously harmed by the information; or
- if the patient expressly directs the doctor to make the decisions, and does not want the offered information. Even in this case, the doctor should give the patient basic information about the illness and the proposed intervention.

To widen the application of therapeutic privilege beyond the circumstances referred to would run counter to the general duty to inform. The issue of therapeutic privilege was also raised in Chapter 2 in the discussion on ethics.

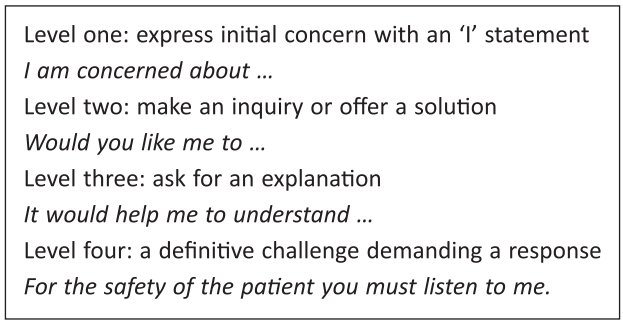


Figure 4.1 Levels of graded assertiveness and examples

The person giving consent has the legal capacity to give such consent

Legal capacity or competence to give or refuse consent has a number of components, whether it relates to mental capacity or age. These were identified in the English case of *Re C (Adult: Refusal of Treatment)*, which addressed the question of whether a man who suffered from a mental illness was capable of refusing treatment to amputate a limb which was gangrenous.[34] Here Thorpe J determined that he had capacity, and defined capacity as a sufficient understanding of 'the nature, purpose and effects of the proffered treatment'.[35] Devereux and Parker (2006) make the point that the concept of competency has both an ethical and a legal function. From an ethical perspective, 'competency operates as a gatekeeper' and tells us 'which bioethical principle, respect for autonomy or beneficence, should take precedence in any particular patient's case'.[36] From a legal perspective, competency again acts as a gatekeeper in that it forms one of the elements of a valid consent. Devereux and Parker provide a comprehensive list of abilities generally agreed to be required for competency. The competent individual needs to be able to:

- receive, understand and recall relevant information;
- integrate the information received and relate it to one's situation;
- evaluate benefits and risk in terms of personal values;
- rationally manipulate the information in order to select an option, and give cogent reasons for the choice;
- communicate one's choice to others; and
- persevere with the choice until the decision is acted upon.[37]

Readers may be able to identify a range of people who would struggle to meet all these criteria, and there are a number of exceptions to the general rule, which will be dealt with as required.

ADULTS AND CONSENT

Any person over 18, barring any mental incapacity, can clearly give and withhold consent to treatment. Yet even with adults, situations arise where the issue of consent to treatment or otherwise needs to be carefully considered. The common-law and statutory situations that may arise for consideration in the provision of healthcare services to adults where consent may need to be obtained from a third party, or may not be necessary, will now be examined.

An adult who lacks the intellectual capacity to make a decision

The disability rights movement of the 1960s brought recognition of groups of people who may lack the capacity to make decisions for themselves yet who need access to the same services and opportunities as everyone else in the community. Over the ensuing 20 years each jurisdiction in Australia enacted legislation to protect the rights of adults who, for whatever reason, lacked the full capacity to make their own decisions.[38] In addition, the United Nations' Convention on the Rights of Persons with Disabilities (CRPD) and its Optional Protocol were adopted at the United Nations Headquarters in New York on 13 December 2006, and entered into force internationally on 3 May 2008.

The Intellectual Disability Rights Service (IDRS) explains that Australia was one of the first countries to ratify the CRPD, on 17 July 2008. Its purpose is 'to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms for all people with disability, and to promote respect for their inherent dignity'.[39] A number of the Articles are identified by the IDRS as bearing on the fundamental principles of autonomy, personal decision-making and self-determination and they include:

- Non-discrimination (Art 4);
- Equal protection before the law (Art 5);
- The right to equal recognition before the law (Art 12);
- Access to justice on an equal basis with others (Art 13);
- Freedom from exploitation, violence and abuse (Art 16);

- Protecting the integrity of the person (Art 17);
- Freedom of expression and opinion, and access to information (Art 21).[40]

To help make decisions for people where their full understanding of the nature and consequences of the decision may be absent or less than optimal, a statutory guardianship framework has been developed to ensure that they receive the best support and that the best possible decisions are made with or for them. There is now an excellent website that sets out to provide case law and explanations about guardianship law in Australia as it is generally poorly understood.[41]

The decision-making requirements for an adult are complex and important and include such aspects as accommodation, healthcare and health services, and medical and dental treatment. Usually, financial decisions and management are subject to more intensive and/or circumscribed scrutiny. Section 4(2) of the *Guardianship and Management of Property Act 1991* (ACT) identifies a set of principles to be followed by a decision-maker acting for a protected person:

a) the protected person's wishes, as far as they can be worked out, must be given effect to, unless making the decision in accordance with the wishes is likely to significantly adversely affect the protected person's interests;
b) if giving effect to the protected person's wishes is likely to significantly adversely affect the person's interests — the decision-maker must give effect to the protected person's wishes as far as possible without significantly adversely affecting the protected person's interests;
c) if the protected person's wishes cannot be given effect to at all — the interests of the protected person must be promoted;
d) the protected person's life (including the person's lifestyle) must be interfered with to the smallest extent necessary;
e) the protected person must be encouraged to look after himself or herself as far as possible;
f) the protected person must be encouraged to live in the general community, and take part in community activities, as far as possible.

For the purposes of this chapter, the most important aspect of the guardianship framework is the ability of another person to consent to medical and dental treatment on behalf of the adult who is unable to make the decisions. This consent is known as a 'substitute consent' and occurs 'where a person or agency other than the patient gives consent for medical or dental treatment … This can only occur in accordance with the legislation or an order of the … [relevant institution]'.[42]

To administer this decision-making framework, each jurisdiction has legislation that sets out the rules and parameters for the decision-making. Although all jurisdictions have similar elements, the detail of the legislation does vary between jurisdictions, and nurses will need to acquaint themselves with government policy in relation to guardianship provisions in their own state or territory. The various statutes for each jurisdiction are shown in Table 4.1.

Some statutes set out the objects of the Act and this enables the reader to understand the reasons why parliament enacted the legislation. Some go even further and

Table 4.1
Legislation applying to guardianship decision-making framework

State or territory	Statute
Australian Capital Territory	*Guardianship and Management of Property Act 1991*
New South Wales	*Guardianship Act 1987*
Northern Territory	*Adult Guardianship Act 1988*
Queensland	*Powers of Attorney Act 1998* *Guardianship and Administration Act 2000*
South Australia	*Guardianship and Administration Act 1993*
Tasmania	*Guardianship and Administration Act 1995*
Victoria	*Guardianship and Administration Act 1986*
Western Australia	*Guardianship and Administration Act 1990*

outline how these objects are to be implemented. For example, section 4(2) of the *Guardianship and Administration Act 1986* (Vic) states that:

> 2) It is the intention of Parliament that the provisions of this Act be interpreted and that every function, power, authority, discretion, jurisdiction and duty conferred or imposed by this Act is to be exercised or performed so that-
>
> a) the means which is the least restrictive of a person's freedom of decision and action as is possible in the circumstances is adopted; and
>
> b) the best interests of a person with a disability are promoted; and
>
> c) the wishes of a person with a disability are wherever possible given effect to.

Almost all of the statutes contain a set of principles for the administration of the framework. These principles accord with the 'best interests' definition above, as they usually have similar provision to those found in section 5 of the *Guardianship and Administration Act 1993* (SA):

> Where a guardian appointed under this Act, an administrator, the Public Advocate, the Board or any court or other person, body or authority makes any decision or order in relation to a person or a person's estate pursuant to this Act or pursuant to powers conferred by or under this Act —
>
> a) consideration (and this will be the paramount consideration) must be given to what would, in the opinion of the decision maker, be the wishes of the person in the matter if he or she were not mentally incapacitated, but only so far as there is reasonably ascertainable evidence on which to base such an opinion; and
>
> b) the present wishes of the person should, unless it is not possible or reasonably practicable to do so, be sought in respect of the matter and consideration must be given to those wishes; and
>
> c) consideration must, in the case of the making or affirming of a guardianship or administration order, be given to the adequacy of

existing informal arrangements for the care of the person or the management of his or her financial affairs and to the desirability of not disturbing those arrangements; and

d) the decision or order made must be the one that is the least restrictive of the person's rights and personal autonomy as is consistent with his or her proper care and protection.

In relation to consent to medical or dental treatment, the concept of treatment itself is broken up into a range of different degrees of seriousness of consequences, and thus the people who are able to give consent on behalf of the individual also vary. For example, the *Guardianship and Administration Act 2000* (Qld) identifies the categories of urgent healthcare (s 63), life-sustaining measures in an acute emergency (s 63A), minor, uncontroversial healthcare (s 64), and special healthcare (s 68).

Provision is made under section 63 that healthcare, other than special healthcare, may be carried out without consent if the adult's health provider reasonably considers that the patient has impaired capacity for the health matter concerned; and either that the healthcare should be carried out urgently to address an imminent risk to the adult's life or health; or that the healthcare should be carried out urgently to prevent significant pain or distress to the adult and it is not reasonably practicable to get consent from a person who may give it. However, section 63A also provides for a life-sustaining measure to be withdrawn or withheld without consent if the adult's health provider reasonably considers that the adult has impaired capacity for the health matter concerned; and the commencement or continuation of the measure for the adult would be inconsistent with good medical practice; and consistent with good medical practice, the decision to withhold or withdraw the measure must be taken immediately. Neither of these provisions applies if there is an advance directive to the contrary. Artificial nutrition and hydration is defined as a life-sustaining measure for the purpose of Schedule 2, section 5A of the Act, but not within this section, thereby limiting the range of decisions the healthcare provider can make without reference to the tribunal.

Provision is further made that 'minor, uncontroversial healthcare' may also be given without consent if the healthcare provider considers that the person lacks capacity and reasonably considers that the healthcare is necessary to promote the adult's health and wellbeing; is of the type that will best promote the adult's health and wellbeing; and is minor and uncontroversial. Examples given in section 64 include administration of a tetanus injection and an antibiotic. Provisions throughout the statute prevent patients being treated if they are known to object to the treatment, unless that treatment would cause minimal distress and the person has limited understanding of what the treatment would entail (s 67). However, the objection would still prevail in the event of tissue donation or engagement in research. The consent of a tribunal is required for special healthcare, which includes such interventions as sterilisation, but does not include such treatments as electroconvulsive therapy or psychosurgery under section 68. Most statutes make specific provision for consent to sterilisation. Other special treatments mentioned in other statutes include termination of pregnancy, treatment with particular groups of

medications, tissue donation and participation in medical research. These treatments are not necessarily forbidden, it is just that great care is taken to be transparent and rigorous in making decisions to give consent to them.

Usually there is a hierarchy of people who can give substitute consent. Several statutes use the term 'person responsible' to describe who might give consent. For example, under section 33A(4) of the *Guardianship Act 1987* (NSW) the 'person responsible for a person other than a child or a person in the care of the Director-General' is defined in a hierarchy of descending order as follows:

a) the person's guardian, if any, but only if the order or instrument appointing the guardian provides for the guardian to exercise the function of giving consent to the carrying out of medical or dental treatment on the person,
b) the spouse of the person, if any, if:
    i) the relationship between the person and the spouse is close and continuing, and
    ii) the spouse is not a person under guardianship,
c) a person who has the care of the person,
d) a close friend or relative of the person.

If a formal guardian is appointed, their powers are usually quite specific and often time-limited, so that there is little risk of such a person stepping over their boundaries in relation to the decisions they are appointed to make on the person's behalf. Over and above a formal guardian being appointed, where there is no one to be either a person responsible or a formal guardian (also known as an 'enduring guardian'), then a Public Guardian may be appointed to give consent and make decisions on behalf of the person. Where any 'special' treatment or healthcare (also referred to as 'prescribed treatment') is required, this may need to be decided by a Guardianship Tribunal or even in some cases by the Supreme Court in the exercise of its *parens patriae* jurisdiction. Although most statutes differ slightly in the determination of special treatment and the consent requirements, there is a significant degree of similarity in the intent of the statutes in relation to these hierarchies.

Where there is less certainty is in relation to the withdrawal of life-sustaining treatment. Some jurisdictions have provisions within the statutes for consent to withholding or withdrawing life-sustaining treatment. For example, the *Guardianship and Administration Act 2000* (Qld) makes specific provision for the withholding or withdrawal of life-sustaining treatment, under section 63A, providing the adult's health provider reasonably considers that the commencement or continuation of the measure for the adult would be inconsistent with good medical practice; and consistent with good medical practice, the decision to withhold or withdraw the measure must be taken immediately. A decision to withhold artificial nutrition and hydration was allowed by the Queensland Guardianship and Administration Tribunal in 2006.[43]

HG was a 58-year-old former merchant seaman who developed both Wernicke's encephalopathy and Korsakoff's psychosis as a result of a long history of excessive alcohol consumption. Because he was unable to make financial decisions, in June

2004 the tribunal appointed the Public Trustee of Queensland as HG's administrator for financial matters and the Adult Guardian as a guardian to make decisions in relation to his future accommodation. On 21 January 2006, HG had a brain-stem stroke which left him unable to swallow and completely paralysed except for the ability to move his eyes up and down and blink. HG was taken to the Acute Stroke Unit at a Brisbane hospital where it was concluded that his pre-stroke cognition was likely to have remained intact but he had no ability to communicate except possibly by blinking. This condition is known as 'locked-in-syndrome' (LIS). A decision was made to withdraw life support but former carers from his group home sought a review of the decision. After an extensive review of the tribunal's jurisdiction to hear the case and evidence from three medical experts, and having considered the general principles and healthcare principles that were relevant to this case, the tribunal determined that it should consent to the withdrawal of artificial hydration currently being provided to HG, and the withholding of artificial nutrition.

This type of reasoning has recently been supported in New South Wales following a rather uncertain start in an earlier decision.[44] The case of *Re BAH*[45] concerned a 56-year-old woman with a mild intellectual disability who had a terminal illness for which the treating team wanted to introduce an end-of-life care regime that included (*inter alia*) a not-for-resuscitation order. President Robinson of the Guardianship Tribunal of New South Wales supported the concept of consenting to limit the treatment.

The weight of case law supports the view that, in certain circumstances, limiting treatment can support the welfare and best interests of a patient. The tribunal considers that limiting treatment can also promote and maintain a person's health and wellbeing. The nature and circumstances of the particular individual's state of health must be considered. Giving treatment which is futile does not promote a patient's health and wellbeing, particularly when that treatment is also burdensome and intrusive. At the end of life, a decision which promotes health and wellbeing may be a decision which allows a person to die in comfort and with dignity.

The tribunal considers that the circumstances in which limiting treatment can promote and maintain a person's health and wellbeing may well be exceptional, but can exist at the end of life. As Morris J said in *Public Advocate v RCS (Guardianship)* [2004] VCAT 1880:

> The contrary argument is predicated upon the proposition that it is always in a person's best interests to live. I cannot accept this. Death is an inevitable consequence of life on this earth. When death stares one in the face or when treatment is futile, the person concerned or the trusted agent or guardian may conclude that it is in the best interests of the person to refuse medical treatment and to allow the person to pass away.[46]

An involuntary patient deemed to be mentally ill in accordance with relevant mental health legislation in each state or territory

There are essentially two types of patients who are admitted to psychiatric hospitals: voluntary and involuntary patients. The voluntary patient presents himself or herself for treatment and professional care and retains the right to give and withhold consent to treatment and leave hospital at any time. The involuntary patient

is admitted for treatment against his or her wishes and, in some circumstances as set out in the legislation, has no legal capacity to give or withhold consent to treatment. There are legislative safeguards in the Acts to protect the patient's interests, while at the same time permitting hospital authorities to carry out therapeutic procedures on such patients if considered necessary. This matter is discussed at length in Chapter 11.

Emergency situations

No consent is required where the patient is unconscious or seriously ill and the situation calls for immediate intervention in order to save a person's life. The overriding duty of care which arises in such emergency situations negates the need for consent on the grounds of the doctrine of emergency or necessity. However, the treatment required must be an urgent treatment required to save life or prevent severe and long-lasting deterioration to the patient. Kerridge et al. state that 'tort law appears to be more settled and clearly requires threat of imminent harm: *London Borough of Southwark v Williams* [1971] Ch 734'.[47]

Blood transfusions and other treatments

Problems arise where the adult patient is conscious and refusing treatment. The situation that occasionally occurs is where a patient refuses blood transfusions on the grounds of religious beliefs. At common law, an adult has the right to refuse such treatment and hospitals have no authority to override that decision. An example of that situation is the case referred to earlier in this chapter of the Jehovah's Witness patient (Mrs Malette) who sued the treating doctor for battery on the grounds that he had overridden her express objections in the form of a printed signed card carried in her purse which stated that, because of her religious convictions, she did not want any blood transfusions.[48] In upholding Mrs Malette's claim for damages for battery the Appeal Court stated, in part, as follows:

> While the law may disregard the absence of consent in limited emergency circumstances, it otherwise supports the right of competent adults to make decisions concerning their own healthcare by imposing civil liability on those who perform medical treatment without consent.
>
> … To transfuse a Jehovah's Witness in the face of her explicit instructions to the contrary would, in my opinion, violate her right to control her own body and show disrespect for the religious values by which she has chosen to live her life.[49]

And further:

> … the state may in certain cases require that citizens submit to medical procedures in order to eliminate a health threat to the community or it may prohibit citizens from engaging in activities which are inherently dangerous to their lives. But this interest does not prevent a competent adult from refusing life preserving medical treatment in general or blood transfusions in particular.[50]

The only way a hospital could seek to override an adult patient's wishes in such a matter would be to seek the intervention of either the Supreme Court of the state or territory or to seek advice from the Guardianship Board as to whether consent to a blood transfusion may be granted. There have been two Australian cases determined by Guardianship Boards that, on the interventions of their families, overturned the express wishes of the patients not to receive blood transfusions.[51] In the 1998 Victorian case of *Qumsieh* (or *Q's case*) the decision was made very narrowly upon the specific facts of the case and does not set out clear legal principles. The decision in *Q's case* has been criticised as it seems to disregard some of the provisions of the Victorian *Medical Treatment Act 1988*. The second decision, made in 2004 in New South Wales, *In AB*, was also unusual, based on the family's desire for the man to receive a transfusion in disregard of his express written wish not to do so.[52]

Treatment of a spouse

Despite a belief still held in many quarters, there is no legal provision requiring hospitals to obtain the consent of the remaining spouse where a husband or wife undergoes treatment or an operation of any sort. The type of operation which generally attracted this requirement in hospitals was when the wife was having a tubal ligation, laparoscopic sterilisation or termination of pregnancy. Equally, where the husband was admitted for a vasectomy, the same requirement applied. It is to be hoped that when a husband or wife chooses to have such an operation, they will discuss it between themselves as an accepted part of the marital relationship. However, should a husband or wife refuse or fail to discuss such or any medical treatment with their spouse, he or she is quite able to give valid consent to such treatment. The only situations where the consent of a spouse, relative or guardian may be legally required are provided for in legislation; for example:

- guardianship or mental health legislation, which allows for an appointed guardian to consent to medical treatment where the person lacks legal capacity;
- human tissue legislation (the *Human Tissue Acts*) of all states and territories, which provides that the 'nearest available next of kin' or similar phrase is able to consent to the removal of organs from a deceased person if the deceased person's wishes are unknown or unable to be ascertained;
- *in-vitro* fertilisation programs provided for by legislation require the consent of both husband and wife to participate in the program; and
- adoption legislation, which provides that the consent of both partners to a marriage must agree to adopt a child.

STATUTORY PROVISIONS

Some states and territories and the Commonwealth have imposed certain statutory provisions which enable certain authorities to treat adults without their consent. As an example, section 47EAA of the *Road Traffic Act 1961* (SA) provides for the taking of blood and oral fluids for analysis from a person who is involved in a motor vehicle accident. If that person is admitted to hospital as a result of the motor vehicle accident, there is an obligation on the treating doctor or the doctor's agent (generally a nurse) to take a blood sample without the patient's consent.

TEMPORARY FACTORS WHICH MIGHT IMPAIR CAPACITY

Although the normal assumption is that adults are considered to have capacity to give consent except in unusual circumstances, in a number of cases, the courts have decided that a person's capacity was temporarily impaired. In *Re T*, a woman who was a Jehovah's Witness was given a blood transfusion whilst ventilated following a postpartum haemorrhage despite her express wishes to the contrary.[53] However, she had been given incorrect information about the alternative treatments available. It was held that it would not be unlawful to give her a blood transfusion because her decision to refuse one had been based on incorrect information. In the course of his judgment, Lord Donaldson, whilst making clear that a person of capacity had the right to refuse treatment, described *obiter dictum* a number of other possible scenarios where a temporary loss of capacity might occur, as follows:

> However, the presumption of capacity to decide, which stems from the fact that the patient is an adult, is rebuttable. An adult patient may be deprived of his capacity to decide either by long-term mental incapacity or retarded development or by temporary factors such as unconsciousness or confusion or the effects of fatigue, shock, pain or drugs.[54]

Findings of temporary loss of capacity have recently been made in two cases where pregnant women were 'needle phobic' and refused to have the anaesthetic needle for caesarean section.[55] In *Re L*, Kirkwood J found that the patient, who was in obstructed labour, had an extreme needle phobia which:

> … amounted to an involuntary compulsion that disabled L from weighing treatment information in the balance to make a choice. Indeed it was an affliction of a psychological nature that compelled L against medical advice with such force that her own life would be in serious peril.[56]

Clearly these situations would not be the norm, but it is worth noting that there have been situations where the courts have found that it was acceptable to administer treatment against the patient's expressed wishes because it was believed that they had temporarily lost the capacity to make a rational decision.

MINORS AND CONSENT

Traditionally, the legal definition of a minor was a person below 18 years of age, and the term 'minor' was used in legislation dealing with legal matters relating to people of that age.[57] Where legislation was designed for more protective purposes the term 'children' has tended to be used.[58] More recently a distinction has been drawn between children and young people. The *Children and Young People Act 1999* (ACT) defines a 'child' as a person under the age of 12 (s 7) and a 'young person' as a person aged 12 or older but not yet an adult (s 8). In New South Wales, under section 3 of the *Children and Young Persons (Care and Protection) Act 1998*, a 'child' is defined (except for the purposes of employment) as a person under 16 years of age and a 'young person' as someone aged 16 or over but under 18. However, not all legislation makes the distinction even when it uses both terms. In the Victorian *Children, Youth and Families Act 2005* (s 3) the term 'child' is defined as:

> a) in the case of a person who is alleged to have committed an offence, a person who at the time of the alleged commission of the offence was under the age of 18 years but of or above the age of 10 years but does not include any person who is of or above the age of 19 years when a proceeding for the offence is commenced in the Court; and
>
> …
>
> b) in any other case, a person who is under the age of 17 years or, if a protection order, a child protection order within the meaning of Schedule 1 or an interim order within the meaning of that Schedule continues in force in respect of him or her, a person who is under the age of 18 years.

The term 'young person' is not defined.

The New South Wales Law Reform Commission (NSWLRC), in its Report 119, *Young People and Consent to Health Care*,[59] defines a young person as one under the age of 18 years, but then goes on to recommend that the following principles should be incorporated into future legislation:

- Young people should be informed about matters relating to their health care, to the extent and in a manner appropriate to their age and maturity, and should be given the opportunity to express their views freely about these matters, and their views should be given due weight in accordance with their age and maturity.
- The developing autonomy of the young person should be acknowledged.
- Respect should be given to the responsibilities and role of parents in the health care of their child or, where applicable, the members of the extended family or persons legally responsible for the young person, in a manner consistent with the evolving capacities of the young person.
- Account should be taken of the culture, disability, language, religion and sexuality of the young person and, if relevant, those with parental responsibility for the young person.
- Access by young people to appropriate health care should be promoted.
- The best interests of the young person should be the primary consideration.[60]

The current situation with the common law is that a child or young person is legally competent to give a valid consent to treatment if the child is capable of understanding the nature and consequences of the proposed treatment. This was confirmed in the High Court of Australia in a case usually referred to as *Marion's case*, where the question of whether the parents of a 14-year-old girl with severe intellectual and physical handicap could give consent for her to be sterilised, or whether this consent could only be given by the court.[61] In determining whether or not minors under 16 years could consent to treatment at all, the majority judgment was that:

> A minor is … capable of giving informed consent when he or she achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.[62]

The High Court recognised that, although this concept of parental power diminishing as the authority of the minor to meet the above test increases, it 'lack[s] the certainty of a fixed age rule, [it] accords with experience and with psychology'. They went on to say that this 'should be followed in this country as part of the common law'.[63] Note that the level of understanding for minors at common law is therefore currently higher than that for adults. Adults are only required to understand 'in broad terms', whereas minors are required to 'understand fully' what is proposed.

In some jurisdictions this has been incorporated into statute. For example, section 12 of the South Australian *Consent to Medical Treatment and Palliative Care Act 1995* makes provision for a medical practitioner to administer medical treatment to a child if either:

> a) the parent or guardian consents; or
> b) the child consents and —
> i) the medical practitioner who is to administer the treatment is of the opinion that *the child is capable of understanding the nature, consequences and risks of the treatment* and that the treatment is in the best interest of the child's health and well-being; and
> ii) that opinion is supported by the written opinion of at least one other medical practitioner who personally examines the child before the treatment is commenced. [emphasis added]

Although the common law does not apply a specific age cut-off point, some statutes still adopt 14 years as an accepted age for such purposes. For example, in New South Wales, the age of 14 has been formally accepted by its insertion into section 49(2) of the *Minors (Property and Contracts) Act 1970*, as far as a child's ability to consent to medical and dental treatment is concerned. Similarly, in South Australia, section 6 of the *Consent to Medical Treatment and Palliative Care Act 1995* permits a young person of 16 years of age or over to consent to medical or dental treatment. However, government policies are beginning to apply an amalgam of the common law and statute law to assist healthcare professionals in the difficult task of determining how to manage the ability of minors to consent to treatment. For example, section 25.2 of the New South Wales Policy Directive PD2005_406, although beginning by stating that 'if the patient is under the age of 14 years, the consent of the parent or guardian is necessary', goes on to say that:

> Generally, the age at which a young person is sufficiently mature to consent independently to medical treatment depends not only on their age but also on the seriousness of the treatment in question relative to their level of maturity. The health practitioner must decide on a case-by-case basis whether the young person has sufficient understanding and intelligence to enable him or her to fully understand what is proposed.[64]

Nowadays a healthcare practitioner has access to resources when there is conflict between parents and young people about consent to medical treatment. The NSWLRC suggests that:

> Although the issue has not been tested in NSW, a prudent doctor would be unlikely to continue to treat a child or young person when he or she became aware that the medical treatment was against the wishes of one of the parents.[65]

However, the NSWLRC does go on to suggest that in New South Wales both the Family Court and the Supreme Court have jurisdiction over aspects of health-care for children, and the Director General of the Department of Community Services (howsoever named) can also be called upon for assistance.[66] An example of where the wishes of a parent or guardian in relation to children have been overturned by the courts occurred in New South Wales in *K v Minister for Youth and Community Services*.[67] The relevant facts are set out below.

A 15-and-a-half-year-old ward of the state became pregnant and, on medical advice, sought a termination of pregnancy. As the child's guardian, the then Minister for Youth and Community Services refused to give his consent to the procedure. The girl, with the aid of a pro-abortion lobby group, challenged the minister's decision to refuse consent. The judge who heard the matter overturned the minister's decision and authorised the termination on the basis that medical evidence showed it was in the girl's best interests and it was being conducted within the state's legal requirements for a termination of pregnancy.

Judicial approval is usually required in relation to what are referred to as special procedures or treatments which include research involvement, procedures such as sterilisation, termination of pregnancy and medication such as hormonal treatment for long-term contraception, psychotropic medications in out-of-home situations and long-term administration of drugs of addiction. For example, section 175 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) sets the penalty for carrying out 'special medical treatment' otherwise than in accordance with the section as seven years' imprisonment.

Under the section a medical practitioner may only carry out special medical treatment on a child if either they are of the opinion that it is necessary, as a matter of urgency, to save the child's life or to prevent serious damage to the child's health, or if the Guardianship Tribunal consents to the carrying out of the treatment. The Guardianship Tribunal can only give consent to the carrying out of special medical treatment on a child if it is satisfied that it is necessary to carry out the treatment on the child in order to save the child's life or to prevent serious damage to the child's psychological or physical health.

In section 175 'medical treatment' includes:

a) any medical procedure, operation or examination, and
b) any treatment, procedure, operation or examination that is declared by the regulations to be medical treatment for the purposes of this section.

and 'special medical treatment' means:

a) any medical treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out, not being medical treatment:
   i) that is intended to remediate a life-threatening condition, and

ii) from which permanent infertility, or the likelihood of permanent infertility, is an unwanted consequence, or

b) any medical treatment for the purpose of contraception or menstrual regulation declared by the regulations to be a special medical treatment for the purposes of this section, or

c) any medical treatment in the nature of a vasectomy or tubal occlusion, or

d) any other medical treatment that is declared by the regulations to be special medical treatment for the purposes of this section.

Many young people in the 14 to 18 years age group seek medical treatment that they do not wish their parents to know about. In such circumstances, a young person is able to give a valid consent to treatment, subject to the legislative and common-law principles already stated. The question of confidentiality in these situations is quite complex, and does create significant dilemmas for healthcare professionals. However, McMahon makes the point that: 'It is generally conceded that minors who are competent to consent to healthcare should also be afforded confidentiality in relation to that care'.[68]

As with adults, there are certain situations where consent is not required or, specifically with children, where parental refusal to consent to treatment for a child can be overridden or is not required. These situations are examined below.

Emergency situations

No parental consent is required where the child is unconscious or seriously ill and the situation calls for immediate intervention in order to save the child's life. The overriding duty of care that arises in such emergency situations negates the need for parental consent. For example, if a child with severe injuries were brought into casualty following a motor vehicle accident, the obvious duty that would arise — to treat that child as quickly as possible — would operate as a defence to a suggestion of battery.

Statutory provisions

The major statutory provisions relate to the following:

The administration of blood transfusions without parental consent

Each state and territory makes such provision in differently named statutes but the commonality of the provisions allows a legally qualified medical practitioner to give a blood transfusion to a child without the consent of the parent or guardian, if it can be shown that a blood transfusion is a reasonable and proper form of treatment and it is necessary to save the child's life. Section 21 of the *Human Tissue and Transplant Act 1982* (WA) provides a good example of the types of situations placed upon medical practitioners when wishing to administer a blood transfusion to a child in the absence of parental consent.

1) A medical practitioner may perform a blood transfusion upon a child without the consent of any person who is legally entitled to authorise the blood transfusion if —

a) such person —

i) fails or refuses to so authorise the blood transfusion when requested to do so; or
ii) cannot be found after such search and inquiry as is reasonably practicable in the circumstances of the case;
and

b) the medical practitioner and another medical practitioner agree —
i) as to the condition from which the child is suffering;
ii) that the blood transfusion is a reasonable and proper treatment for that condition; and
iii) that without a blood transfusion the child is likely to die;
and

c) the medical practitioner who performs the blood transfusion on the child —
i) has had previous experience in performing blood transfusions; and
ii) has, before commencing the transfusion, assured himself that the blood to be transfused is suitable for the child.

The individual state and territory provisions are shown in Table 4.2.

Table 4.2
Statutory provisions concerning situations in which parental consent to blood transfusions is not required, or parental refusal to give consent may be overridden

State or territory	Statute
Australian Capital Territory	*Transplantation and Anatomy Act 1978* section 23
New South Wales	*Children and Young Persons (Care and Protection) Act 1998* section 174
Northern Territory	*Emergency Medical Operations Act 1973* section 3
Queensland	*Transplantation and Anatomy Act 1979* section 20
South Australia	*Consent to Medical Treatment and Palliative Care Act 1995* section 13(5)
Tasmania	*Human Tissue Act 1985* section 21
Victoria	*Human Tissue Act 1982* section 24
Western Australia	*Human Tissue and Transplant Act 1982* section 21

Children who are placed under the care of the state

Consent for treatment of children who are the subject of care and protection orders has to be given by the minister or secretary of the relevant government department empowered with the guardianship of such children. In most states and territories, that is the Minister for Youth and Community Services. There are a range of names for the relevant statutes; for example, in Western Australia it is the *Children and Community Services Act 2004*, and in Tasmania, the *Children, Young Persons and Their Families Act 1997*.

Reporting, examination and treatment of children at risk without parental consent

It has now been recognised that there are occasions when it is necessary, for the protection of the child, to remove a child from the parents without their consent and to detain a child in hospital for examination and treatment without parental consent. Such steps are generally required when instances of child neglect or child abuse become known. All states and territories have now made specific provision to deal with these issues, while at the same time making sure that appropriate protection against defamation or other civil actions is afforded to those persons required to report such incidents to the relevant authorities. These statutory provisions are shown in Table 4.3.

The precise wording of the statutory requirements varies, but, as is usual, the major provisions are the same and have been summarised as follows:

- A child for the purposes of these provisions is a person up to the age of 18 years.
- Child neglect or abuse embraces both psychological and physical harm (including sexual abuse).
- There is a duty for healthcare professionals to notify if child neglect or abuse is reasonably suspected.
- The persons who have an absolute duty to notify are medical practitioners as well as a wide range of healthcare and welfare professionals, including nurses and midwives.
- As well as the absolute duty to notify imposed on certain categories of people, there is also the provision that any other person 'may' notify if they reasonably suspect child abuse or neglect.
- On receipt of the notification, the relevant government department is then required to investigate the matter.
- As long as it is made in good faith, the notification and any accompanying report are protected from any civil action, such as defamation.

Table 4.3
Statutory provision for removal of a child and detaining a child in hospital without parental consent

State or territory	Statute
Australian Capital Territory	*Children and Young People Act 2008*
New South Wales	*Children and Young Persons (Care and Protection) Act 1998*
Northern Territory	*Care and Protection of Children Act 2007*
Queensland	*Child Protection Act 1999*
South Australia	*Children's Protection Act 1993*
Tasmania	*Children, Young Persons and Their Families Act 1997*
Victoria	*Children Youth and Families Act 2005* *Child Wellbeing and Safety Act 2005*
Western Australia	*Children and Community Services Act 2004*

- If a child is brought to a hospital as a result of suspected abuse or neglect, a medical practitioner may order that the child be detained in hospital without parental consent. The period of time that a child may be detained in this way varies between state and territory. During the time a child is detained, medical treatment or tests, as deemed necessary, may be carried out without parental consent.

The right to refuse medical treatment

In addition to the need to obtain a patient's consent to treatment, there is also the related right of a person to withhold their consent to treatment. This has been a somewhat controversial topic over the years, both at law and in practice, as health-care professionals have taken some time to accommodate and acknowledge it, since it can clash with their professional culture of intervention to save life. When this professional culture is coupled with the overriding legal obligation, particularly in a hospital environment, of doing all that can be done to save life and preserve health, it is perhaps understandable why some healthcare professionals have in the past found refusal of consent to treatment so difficult.

Concerns about being able to determine the course of treatment, particularly in the face of medical futility at the end of life, have arisen due to the increasing ability to extend life. The challenge has been to decide whether, just because it was *possible* to do more to keep a person alive, whether it was appropriate to do so, if the burden of the proposed therapy outweighed the benefits. As treatment and cure has developed throughout the twentieth century, healthcare practitioners have found it increasingly difficult to discontinue life-prolonging treatment and, therefore, have frequently provided aggressive therapy until the point of death, in some instances depriving the patient of the opportunity for appropriate palliative care. The most recent report from the *Dartmouth Atlas of Health Care*[69] in the United States has this to say about treatment at end of life:

> The intensity of care in the last six months of life is an indicator of the propensity to use life-saving technology. The question of whether more medical intervention is better must be framed in terms of the potential gain in life expectancy for populations living in regions with greater intensity of intervention. Our research has provided evidence that populations living in regions with lower intensity of care in the last six months of life did not have higher mortality rates than those living in regions with higher care intensity.
>
> More than 80% of patients say that they wish to avoid hospitalization and intensive care during the terminal phase of illness, but those wishes are often overridden by other factors. If more intense intervention does not improve life expectancy, and if most patients prefer less care when more intensive care is likely to be futile, the fundamental question is whether the quality of care in regions with fewer resources and more conservative practice styles is better than in regions where more aggressive treatment is the norm.[70]

Start a new report

At the same time, some activist groups, such as those advocating for and opposing euthanasia, have brought the debate about the potential for and problems with end-of-life care into the mainstream, even if the public does not necessarily agree with the goals of either group.[71]

The right to withhold consent to treatment, as much as the right to give consent to treatment, is a fundamental common-law right of all patients of full legal capacity. In essence, therefore, such a right requires no legislative prescription to sustain it. In spite of that, the need for legislation to enshrine the right to withhold consent to treatment, particularly in cases of terminal illness, has been perceived as necessary in some states and territories of Australia. Others have simply developed policy to assist in clarification and implementation of the existing common law. The major argument in support of the need for legislation is to ensure protection from any potential civil and criminal liability on the part of a healthcare practitioner who acts in good faith and in accordance with the expressed wishes of a fully informed, competent patient who refuses medical treatment.

To date the majority of legislation passed by some of the states and territories has been merely a statutory reflection of the common-law position where a person can refuse medical treatment. This type of legislation enables competent adults in certain specified situations to direct that medical treatment be withdrawn or withheld. People may feel that legislative status perhaps offers clearer protection to those with terminal or incurable illnesses, or healthcare professionals who treat them, from potential criminal or civil liability, but in reality, a policy document provides similar clarity of the current legal situation. However, one of the important aspects of codifying the common law is that it has the potential to make mainstream some relatively new practices, such as the development and acknowledgment of advance directives.

Advance directives, advance care planning and proxy decision-making

A critical aspect of patients' rights to refuse treatment is whether that right can be assured if they lack capacity. The development of advance directives,[72] or 'living wills' as they are sometimes known, is one way that people can ensure that their wishes to refuse treatment are known even if they are unable to communicate at the time that the treatment they wish to refuse is under consideration. These advance directives are considered to be of particular importance for patients with dementia, as the prognosis of incapacity is clear from the outset of the disease, and it is thus possible actively to ascertain the patient's wishes about an almost certain future scenario.[73] Currently there is a new emphasis on looking at planning ahead, or advance care planning, as much more of an iterative conversation that all adults need to undertake to ensure they are able to feel comfortable about their financial, physical and mental wellbeing into the future. This is often described as 'Advance Care Planning' or 'Planning Ahead'.[74]

The level of proof required to ascertain what the patient's wishes would be in relation to their treatment was explained in the United States Supreme Court in the case of *Cruzan v Director, Missouri Department of Health*,[75] which identified the requirement for 'clear and convincing evidence'. Advance directives are one way of

obtaining 'clear and convincing evidence' of a patient's wishes about future treatment. An 'Advance Care Directive' is defined by the Advance Care Directive Association Inc, a group of healthcare professionals and experts who provide advice to the public on advance care planning, as:

> … a written statement regarding someone's wishes for their future health care. An *Advance Care Directive* can be made now by anyone who has the capacity to do so. An *Advance Care Directive* is only used if, at some point in the future, the person becomes incapable of making health care decisions for themselves (due to illness or injury).[76]

A possible problem of not having a statutory framework for advance directives may be that many issues, such as duration of effect, liability for healthcare professionals, questions of what may or may not be excluded, management of relatives, and drafting provisions could still be left as both discretionary and optional issues. The only place for legal resolution would then be through the common law, which means that some parties will have been sufficiently dissatisfied with the clinical process of decision-making that they needed to seek resolution from the courts. Concerns about misinterpretation[77] and applicability to future events[78] are acknowledged as being problems with advance directives. However, it seems apparent that the value of clear and convincing evidence of pre-determined wishes in relation to treatment outweighs any disadvantages.

Australia has legislated for advance directives in some states and territories but not others, and the types of medical treatment that can be refused in advance varies from state to state and territory. However, Victoria, which has the most permissive legislation in relation to what treatments might be refused and in what circumstances, reports that because of the *Medical Treatment Act 1988* (Vic) there is very little common law. The Senior Guardian of the Office of the Public Advocate believes this is because most end-of-life decisions are resolved amicably within the policy and legal framework developed by the Act.[79] However, concerns are still being expressed about the relative ongoing disregard for advance directives in some situations,[80] so it seems there is still work to be done.

The different approaches to refusal of treatment taken by the states and territories are set out in Table 4.4.

The right to restrain or detain patients without their consent

The right of a hospital or nursing home to restrain patients against their wishes is of genuine concern to nursing staff who often have to deal with violent, aggressive or dementing patients or residents, or patients whose particular medical condition makes them physically or mentally temporarily unstable and very threatening. Also, some patients who are ill and require continuing care demand to be discharged.

Obviously in most circumstances all competent adults have a legal right not to be restrained or detained — doing so is the third in the trio of trespasses to the person mentioned at the beginning of this chapter. Having said that, the legal right of hospitals and nursing homes to restrain patients or residents without their consent and the right of hospitals to detain patients against their wishes clearly does exist in particular circumstances. Before specific consideration of those particular

Table 4.4
Different approaches to refusal of treatment

State or territory	Provision made	Key features
ACT	*Medical Treatment (Health Directions) Act 2006*	Long title: An Act to provide for directions about the withholding or withdrawal of medical treatment, and for related purposes
NSW[81]	*Advance Planning for Quality Care at the End of Life: Strategic and Implementation Framework* (2011)	The NSW Health Advance Planning for Quality Care at the End of Life: Strategic and Implementation Framework (the Framework) provides direction for NSW Health in developing a system-wide, coordinated, continuous quality approach to advance care planning, including for end of life
NT	*Natural Death Act 1988*	Long title: An Act to provide for, and give legal effect to, directions against artificial prolongation of the dying process
Qld	*Powers of Attorney Act 1998* section 35(1)	By an ***advance health directive***, an adult principal may — (a) give directions, about health matters and special health matters, for his or her future health care; and (b) give information about his or her directions; and (c) appoint 1 or more persons who are eligible attorneys to exercise power for a health matter for the principal in the event the directions prove inadequate; and *Editor's note —* Note this does not include a special health matter. (d) provide terms or information about exercising the power.
SA	*Consent to Medical Treatment and Palliative Care Act 1995*	Long title: An Act to deal with consent to medical treatment; to regulate medical practice so far as it affects the care of people who are dying; and for other purposes. Section 3 — Objects The objects of this Act are: … (b) to provide for medical powers of attorney under which those who desire to do so may appoint agents to make decisions about their medical treatment when they are unable to make such decisions for themselves; and (c) to allow for the provision of palliative care, in accordance with proper standards, to people who are dying and to protect them from medical treatment that is intrusive, burdensome and futile.
Tas	• *Guardianship and Administration Act 1995* • (Part 5: Appointment of enduring guardian) • Website of DHHS Advance Care Planning Fact Sheet[82]	Fact Sheet: An Advance Care Plan is a written statement of your wishes regarding your future medical treatment that is signed and dated. It is sometimes called a 'statement of wishes', 'advance directive' or 'living will'. It helps those involved in your care to know what you want and makes it easier to convey these wishes to others. Unless it is registered as part of the Enduring Guardianship process an Advance Care Plan does not have any legal standing but it does serve to represent your wishes for care.

Table 4.4
Different approaches to refusal of treatment—Cont'd

State or territory	Provision made	Key features
Vic	*Medical Treatment Act 1988*	Section 1 — Purpose The purposes of this Act are- (a) to clarify the law relating to the right of patients to refuse medical treatment; (b) to establish a procedure for clearly indicating a decision to refuse medical treatment; (c) to enable an agent to make decisions about medical treatment on behalf of an incompetent person.
WA	• *Acts Amendment Act (Consent to Medical Treatment) Act 2008* • *Guardianship and Administration Act 1990* section 110P • *Civil Liability Act 2002*	The *Acts Amendment (Consent to Medical Treatment) Act 2008* amended the *Guardianship and Administration Act 1990, Civil Liability Act 2002* and the Criminal Code. Amendments to the *Guardianship and Administration Act 1990* provide a legislative basis for Advance Health Directives. The Advance Health Directive form enables adults over 18 years of age with legal capacity to plan for future medical decisions if they are unable to make decisions for themselves in the future.

circumstances is outlined, it is important to examine the legal context in which these issues arise — and that requires consideration of the elements that constitute the civil wrong of false imprisonment. False imprisonment, like assault and battery and negligence, can be both a civil wrong and a crime. However, as far as nursing staff are concerned, false imprisonment, also like assault and battery and negligence, has greater significance as a civil wrong.

What is false imprisonment?

In essence, false imprisonment is the wrongful and intentional application of restraint upon a person, restricting the person's freedom to move from a particular place or causing the person to be confined to a particular place against his or her will. The 'wrongful' aspect of the restraint means that it is not, expressly or impliedly, authorised by the law. By implication then there are a number of situations where the law does permit people to be detained against their will — the most common example being the detention of people in jail for criminal offences. Putting aside this most obvious example, other situations relevant to nursing staff are dealt with in this chapter.

How is false imprisonment committed?

Apart from the obvious steps of locking a person in a room without any means of escape and against his or her will, it is quite possible to commit the civil wrong of false imprisonment without 'imprisonment' of a person as the term is commonly understood. In fact, neither physical contact nor anything resembling a prison is necessary to constitute false imprisonment. For example, if a lecturer locked the classroom door after the final lecture of the day and there was no other means of

escape for the students inside, that would clearly constitute false imprisonment, even though the lecturer had not physically touched the students and they were not being confined in a prison cell.

In addition, it is not necessary to confine a person physically to constitute false imprisonment. It is sufficient if a person believes he or she is not free to go because of some fear or apprehension that has been created in the person's mind and which acts as a constraint on the person's will. For example, a male patient attends the accident and emergency department of a hospital for emergency treatment for a badly gashed arm. After the appropriate treatment, he is about to leave when the ward clerk presents him with a bill for $50 for the treatment received. The patient states he has got only $5 on him and will pay the bill at a later time. He is told that he is not permitted to leave the hospital until the bill is paid and that he had better make some arrangements to do so otherwise the police will be called. Believing this to be correct, the patient then spends a number of hours in the waiting room trying to contact a friend or relative by phone to ask them to come to the hospital with the required money. Some six hours after the patient was originally ready to leave, a friend arrives with the money and the ward clerk says the patient is now free to leave the hospital.

Although nobody has laid a hand on him or locked him in a room, the patient has clearly been falsely imprisoned. A situation was created in which he genuinely believed he was not free to go and that the police would be called if he should attempt to do so. In fact, as far as paying accounts is concerned, no organisation, hospital or department store can detain a person for failing to pay his or her debts. What they can do is litigate through the appropriate court to recover the money owed.

RESTRAINT MUST BE INTENTIONAL AND COMPLETE

What this means is that the restraint must not only be intended but also be complete in that there is no means of escape. Referring to the earlier example of the lecturer locking the classroom door, if the classroom was on the ground floor and there were plenty of open windows through which the students could climb, then the restraint might have been intentional, but it would not have been complete. Alternatively, if the classroom was on the tenth floor, then any number of open windows would have been to no avail and the restraint would have been complete. At the same time, if a person has the means to escape but does not know it, such a situation would still be false imprisonment, unless it could be shown that a reasonable person would have realised there was a means of escape available.

An interesting example occurred in the case of *Sayers v Harlow Urban District Council*[83] where the courts held that the restraint was total but not intentional. The relevant facts are set out below.

Mrs Sayers went to a toilet cubicle in the council's public rest rooms. The toilets were of the coin-operated type and, after entering the toilet, Mrs Sayers was unable to leave because of a problem with the door handle. She was unable to attract anybody's attention so, having some degree of initiative, Mrs Sayers attempted to climb over the top of the toilet cubicle. In order to do so Mrs Sayers was obliged to place her weight on the toilet roll fitting on the wall of the toilet cubicle. The fitting gave way under her weight and Mrs Sayers slipped and fell to the floor injuring herself.

Mrs Sayers brought an action against the council for false imprisonment and negligence. The court dismissed Mrs Sayers' claim of false imprisonment on the basis that the restraint had been complete but not intentional. The court upheld Mrs Sayers' claim of negligence against the council because of the faulty door handle. However, the court reduced her damages by 25 percent on the grounds of contributory negligence in that she should not have relied on the toilet roll fitting in the cubicle to carry her weight while attempting to escape.

In the New South Wales case of *Hart v Herron* the plaintiff, Mr Hart, successfully sued Dr Herron for, amongst other things, wrongful imprisonment when he was admitted to Chelmsford Private Hospital and administered narcosis therapy and electroconvulsive therapy (ECT) without his consent.[84] It was held that the restraint amounted to wrongful imprisonment even though he had no recollection of it happening.

Defences to an action alleging false imprisonment

REASONABLE CONDITION

It is not false imprisonment to prevent a person from leaving a particular premises because he or she does not wish to fulfil a reasonable condition subject to which the person entered them. The matter of *Herd v Weardale Steel Co*[85] provides an example of this situation. The relevant facts are set out below.

Mr Herd was employed as an underground miner. The usual routine was that the workmen would report for duty at a particular time and would be taken by lift down the mineshaft, where they would work their shift. It was understood that, except in certain emergencies, the workmen would remain down the mineshaft until the completion of their shift and would then be brought to the surface by lift. Mr Herd was taken down the mineshaft, assigned to a job, which he then refused to do, and demanded to be taken to the surface. The management refused to do so until the normal lift time some hours later. Mr Herd brought an action against his employers for false imprisonment. His claim failed on the basis that Mr Herd entered the lift to go down the mineshaft on the reasonable condition that he would undertake a particular job and be returned to the surface at a particular time. In doing so Mr Herd had submitted to a restriction on his liberty and the employers were not liable.

LAWFUL ARREST IN RELATION TO CRIMINAL OFFENCES

A lawful arrest is not false imprisonment. Accordingly, for example, a police officer or other authorised person who arrests another person, pursuant to the issue of a valid warrant for that person's arrest, cannot be sued for false imprisonment.

SPECIFIC DEFENCES IN RELATION TO HOSPITALS AND HEALTHCARE GENERALLY

The right of hospitals and healthcare centres to detain or restrain patients arises by the operation of statutory or common law as follows.

Detention of patients

- The relevant mental health legislation in each state and territory gives health authorities limited power to detain those people, against their will, who come

within the provisions of the legislation. The power to admit, treat and detain involuntary patients under the provisions of the mental health legislation of each state and territory is fully covered in Chapter 11.

- Relevant legislation in each state and territory gives health and welfare authorities the power to detain a child in hospital or an appropriate place without parental consent for the purposes of examination and treatment in the case of suspected child abuse. This matter was covered earlier in this chapter in the section headed 'Reporting, examination and treatment of children at risk without parental consent'.
- Specific provision under public health legislation may provide for the detention and treatment of persons with particular diseases in the interests of public health or safety, or obligatory notification by medical practitioners to health authorities of persons with 'proclaimed' notifiable diseases. For example, the Commonwealth *Quarantine Act 1908* empowers health authorities to detain people attempting to enter Australia with suspected infectious diseases. They can be detained onboard ship or in a quarantine station.

Apart from any statutory powers to detain, which have already been referred to, there is no common-law power to detain a person in hospital against that person's wishes, no matter how ill the person may be. In situations where a patient of full legal capacity insists on leaving hospital against all medical advice, he or she must be allowed to do so. As a matter of policy, most healthcare facilities will have a standard voluntary discharge form, which the patient should be asked to sign, indicating that he or she is leaving the hospital against medical advice. If the patient refuses to sign such a form the patient must still be permitted to leave and the appropriate entry made in the patient's notes, detailing the events surrounding the patient's departure from hospital. The patient's relatives or carers should be advised as soon as possible of the patient's intentions.

Restraint of patients

There are occasions in hospitals and nursing homes when patients become violent, aggressive and extremely difficult to properly control and care for. The reasons for this aggression are many and varied and a great deal of valuable advice is available to healthcare professionals on dealing with violence and aggression.[86] However, if strategies to de-escalate the violence or aggression fail, or if for some other clinical reason the patient is a danger to themselves or others, nursing staff may need to restrain a patient in order to protect:

- the patient from injury — particularly if the patient is a child;
- other patients who may be at risk;
- themselves from unnecessary risk or harm, but remembering that such restraint is for protection and not for the convenience of staff.

As far as nursing staff are concerned, the application of any restraint to a patient or resident against their wishes must only be done following a careful consideration

of the issues involved and consultation with the patient's medical practitioner and, where possible, the patient's relatives. Every hospital and healthcare organisation should have a clear policy on this issue, which should be known to all nursing staff. In compiling such a policy the following points should be considered:

- the circumstances in which restraint may be deemed necessary;
- the type of restraint that may be applied by nursing staff in an emergency before a medical officer can arrive — for example, standard lamb's wool arm and leg restraints or cot sides;
- the need to notify the appropriate medical officer;
- the need for the patient to be examined by a medical officer to confirm the need for restraint and to order any other measures that may be necessary, such as a change of medication or the need to transfer the patient to a more suitable location or ward to be cared for;
- the written confirmation of the need for restraint to be made in the patient's notes by the medical officer;
- regular assessment and review of any restraint applied;
- the patient's or resident's relatives should be advised and consulted of any measures to be taken to restrain the patient before they become alarmed or unduly concerned.

The Australian Government Department of Health and Ageing has produced a decision-making tool for responding to issues of restraint in aged care. The document is well set out and, whilst obviously designed with aged care in mind, is equally of value in the acute care sector.[87] It is available electronically and will be most helpful both in avoiding the use of restraint and in the safest and most effective way of using restraint in acute and aged care facilities.

CONCLUSION

The question of giving and refusing consent to treatment is of considerable importance for nurses. However, despite the level of concern which the question of consent generates, in reality the essence of this area of law relates to respect for people's integrity and care and diligence in the communication of information. Many health organisations in Australia at national, state and local level, in addition to many consumer groups, have undertaken a lot of work and produced valuable aides to assist healthcare professionals and consumers alike to understand their rights and responsibilities.

Endnotes

Note: All links given below were last accessed on 24 January 2012.

1) Kennedy I, 'The patient on the Clapham Omnibus', (1984) *MLR* 47 at 454, 460.
2) Blake M, 'Religious beliefs and medical treatment: The challenge to patient consent', (2007) *Bond LR* 19 (1) at pp 3–4 http://epublications.bond.edu.au/blr/vol19/iss1/2/.

3) *Schloendorff v Society of New York Hospital* (1914) 211 Ny 125, 129; 105, NE 92, 93.
4) *Malette v Shulman* (1991) 2 *Med LR* at 162.
5) Ibid, at 165.
6) Ibid, at 163.
7) Piper D and Iedema R, *Literature Review: Incident Disclosure Policy, Legal Reform and Research since 2008*, Centre for Health Communication, University of Technology Sydney, and Australian Commission on Safety and Quality in Health Care, 2011, p 22.
8) *Rogers v Whitaker* (1992) 175 CLR 479 at 484.
9) Ibid, at 490. This was reiterated in *Rosenberg v Percival* [2001] HCA 18.
10) *Malette v Shulman* (1991) 2 *Med LR* at 163.
11) Ibid.
12) Two more recent Australian cases determined by Guardianship Boards overturned the express wishes of the patients not to receive blood transfusions at the requests of their families — *Qumsieh v Guardianship and Administration Board* (1998) 14 VAR 46 and *In AB (application for consent to medical treatment)* (NSWGT, 2004/1867, 6 April 2004, unreported). For further discussion about these and other cases see Stewart C, *'Advance directives: Disputes and dilemmas'*, in Freckleton I and Petersen K (eds), *Disputes and Dilemmas in Health Law*, Federation Press, Sydney, 2006, pp 48–60; and Blake M, 'Religious beliefs and medical treatment: The challenge to patient consent', (2007) *Bond LR* 19 (1) http://epublications.bond.edu.au/blr/vol19/iss1/2/. For a balanced account of caring for Jehovah's Witnesses, including possible alternative options for treatment, see Panico M, Jenq G and Brewster U, 'When a patient refuses life-saving care: Issues raised when treating a Jehovah's Witness', (2011) *American Journal of Kidney Diseases* 58 (4) at 647–53.
13) National Health and Medical Research Council (NHMRC), *General Guidelines for Medical Practitioners on Providing Information to Patients*, 2004(a), http://www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/e57.pdf.
14) NHMRC, *Communicating with Patients: Advice for Medical Practitioners*, 2004(b), http://www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/e58.pdf.
15) See, for example, Office of Safety and Quality in Healthcare, Western Australia Department of Health, *Consent to Treatment Policy for the Western Australian Health System*, 2010, http://www.health.wa.gov.au/circularsnew/pdfs/12499.pdf; NSW Health, 'Consent to medical treatment — patient information', Policy Directive PD2005_406, 2005, http://www.health.nsw.gov.au/policies/pd/2005/PD2005_406.html.
16) Fitzroy Legal Service Inc., 'Information and consent' in *The Law Handbook*, 2010, http://www.lawhandbook.org.au/handbook/ch19s01s02.php#Ch132Se51394. For a consumer-developed document see *What should I be aware of before consenting to medical treatment?* Consumer Health Forum of Australia, 2008, https://www.chf.org.au/pdfs/fac/fac-aware-before-medical-treatment.pdf.
17) *Hart v Herron* [1984] Aust Torts Report 80-201.
18) Office of Safety and Quality in Healthcare, Western Australia Department of Health, *Consent to Treatment Policy for the Western Australian Health System*, 2010, http://www.health.wa.gov.au/circularsnew/pdfs/12499.pdf.
19) The Hon. Wootton J H, QC, *Report of the Royal Commission into Deep Sleep Therapy*, vol 6, 1990, p 76.
20) *Rogers v Whitaker* (1992) 175 CLR 479 at 484.
21) These early American decisions acknowledged: 'a patient needed adequate information about the nature of proposed treatment, its risks and feasible alternatives in order to make an intelligent choice about whether or not to undergo it', in Teff H, 'Consent to medical procedures: Paternalism, self-determination or therapeutic alliance', (1985) *LQR* 101 at 432.
22) *Rogers v Whitaker* (1992) 175 CLR 479 at 490.
23) Ibid.
24) NHMRC, 2004(a), online, op. cit., p 11.
25) NSW Health, 2005, online, op. cit., p 16.
26) Ibid, p 13.
27) Lubbeke A, Suva D, Perneger T and Hoffmeyer P, 'Influence of preoperative patient education on the risk of dislocation after primary total hip arthroplasty', (2009) *Arthritis Care and Research*, 61 (4) at 552–8: in particular note the reference list to this paper that identifies an extensive range of research papers that recognise the importance of pre-operative information as a prevention for a range of complications.
28) *Health Practitioner Regulation National Law Act 2009* (Qld) Part 8, section 140.

29) Reason J, *Human Error*, Cambridge University Press, New York, 1990.
30) Wilson R, Runciman W, Gibberd R et al., 'The quality in Australian health care study', (1995) *MJA* 163 at 458.
31) Flight Safety Foundation website, http://flightsafety.org.
32) Curtis K, Tzannes A and Rudge T, 'How to talk to doctors — A guide for effective communication', (2011) *International Nursing Review* 58, 13–20, http://onlinelibrary.wiley.com/doi/10.1111/j.1466-7657.2010.00847.x/full.
33) NHMRC, 2004(a), online, op. cit., p 12.
34) *Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290.
35) Ibid, at 295.
36) Devereux J and Parker M, *'Competency issues for young persons and older persons'*, in Freckleton I and Petersen K (eds), *Disputes and Dilemmas in Health Law*, Federation Press, Sydney, 2006, p 54.
37) Ibid, p 58.
38) Bidmeade I, *'History of disability in South Australia'*, 2007, http://history.dircsa.org.au/stories/ian-bidmeade/. This link contains information on all jurisdictions.
39) Fogarty B, *Guardianship and Administration Laws across Australia*, Intellectual and Disability Rights Service, 2009, p 3, http://www.idrs.org.au/_pdf/Guardianship_and_administration_laws_across_Australia_by_Ben_Fogarty.pdf.
40) Ibid.
41) Stewart C et al., *Discovering Australian Guardianship Law*, 2012, http://www.austguardianshiplaw.org/.
42) Guardianship and Administration Board, *Consent to Medical and Dental Treatment*, 2007, http://www.guardianship.tas.gov.au/consent_for_treatment.
43) *HG, Re* [2006] QGAAT 26 (5 May 2006), http://www.austlii.edu.au.
44) *WK v Public Guardian (No 2)* [2006] NSWADT 121 (20 April 2006), http://www.austlii.edu.au.
45) *BAH, Re* [2007] NSWGT 1 (5 February 2007), http://www.austlii.edu.au.
46) *Public Advocate v RCS (Guardianship)* [2004] VCAT 1880 at [74] and [75].
47) Kerridge I, Lowe M and Stewart C, *Ethics and Law for the Health Professions*, 3rd ed, Federation Press, Sydney, 2009, p 293.
48) *Malette v Shulman* (1991) 2 *Med LR* at 162.
49) Ibid, at 165.
50) Ibid, at 166.
51) *Qumsieh v Guardianship and Administration Board* (1998) 14 VAR 46; *Qumsieh v Guardianship and Administration Board & Pilgrim* [1998] VSCA 45; (Winnecke P, Brooking and Ormiston JJA, 17 September 1988, unreported).
52) *In AB (application for consent to medical treatment)* (NSWGT, 2004/1867, 6 April 2004, unreported).
53) *Re T* [1993] Fam 95.
54) Ibid, at 95.
55) *Re MB* [1997] EWCA Civ 1361; *Re L* (Fam Div, Kirkwood J, 5 December 1996, unreported).
56) *Re L* (Fam Div, Kirkwood J, 5 December 1996, unreported) at 837.
57) For example, *Minors (Property and Contracts) Act 1970* (NSW); *Minors Contracts (Miscellaneous Provisions) Act 1979* (SA); and *Minors Contracts Act 1988* (Tas).
58) For example, the *Child Protection Act 1999* (Qld).
59) New South Wales Law Reform Commission (NSWLRC), *Report 119: Young People and Consent to Health Care*, 2008, http://www.lawlink.nsw.gov.au/lawlink/lrc/ll_lrc.nsf/vwFiles/r119.pdf/$file/r119.pdf.
60) Ibid, p xii.
61) *Department of Health and Community Services (NT) v JWB (Marion's case)* (1992) 175 CLR 218.
62) Ibid, at 237–8.
63) Ibid.
64) NSW Health, 2005, online, op. cit., p 20.
65) NSWLRC, 2008, online, op. cit., p 142.
66) Ibid.
67) *K v Minister for Youth and Community Services* (1982) 1 NSWLR 311.
68) McMahon M, *'Re-thinking confidentiality'*, in Freckleton I and Petersen K (eds), *Disputes and Dilemmas in Health Law*, Federation Press, Sydney, 2006, p 568.
69) Dartmouth Institute for Health Policy and Clinical Practice, *Dartmouth Atlas of Health Care: End of Life Care*, 2012, http://www.dartmouthatlas.org/data/topic/topic.aspx?cat=18.
70) Ibid.
71) Blasi Z V, Hurley A C and Volicer L, 'End-of-life care in dementia: A review of problems, prospects and solutions in practice',

(2002) *Journal of American Directors Association* 3:57–65; Jones R G, 'Ethical and legal issues in the care of people with dementia', (2001) *Reviews in Clinical Gerontology* 11:245–68; Volicer L, Cantor M D, Derse A R, Edwards D M, Prudhomme A D, Rasinski-Gregory D C, Reagan J E, Tulsky J A and Fox E, 'Advance care planning by proxy for residents of long-term care facilities who lack decision-making capacity', (2002) *Journal of the American Geriatric Society* 50:761–7. For an extensive discussion on policy and legislation in end-of-life care, see Chiarella M, *Policy in End-of-life Care: Education, Ethics, Practice and Research*, Quay Books, London, 2006.

72) Also known as advance care directives and advance health directives.

73) Stewart C, 'Advanced directives. The right to die and the common law: Recent problems with blood transfusions', (1999) *Melbourne University Law Review* 6.

74) See, for example, the New South Wales Government website that incorporates a range of documents, policies, legislation and general advice for planning ahead, http://www.planningaheadtools.com.au/.

75) *Cruzan v Director, Missouri Department of Health* 497 US 261 (1990).

76) Advance Care Directive Association Inc., *What is advance care planning?* 2012, http://www.advancecaredirectives.org.au/index.html.

77) Bonner S, Tremlett M and Bell D, 'Are advance directives legally binding or simply the starting point for discussion on patients' best interests?' (2009) *British Medical Journal* 339 b4667, http://www.bmj.com/content/339/bmj.b4667.

78) Davies M, 'Are advance directives legally binding or simply the starting point for discussion on patients' best interests? Legal advice', (2009) *British Medical Journal* 339 b4693, http://www.bmj.com/content/339/bmj.b4693.

79) Carter B, 'Legal issues at end of life: A guardian's perspective', (2003) *Chisholm Health Ethics Bulletin* 8(3): 4–6.

80) Stewart C, 'Advance directives: Disputes and dilemmas', in Freckleton I and Petersen K (eds), *Disputes and Dilemmas in Health Law*, Federation Press, Sydney, 2006; Wilmott L, White B and Howard M, 'Refusing advance refusals: Advance directives and life-sustaining medical treatment', (2006) *Melbourne University Law Review* 7 30(1) at 211, http://www.austlii.edu.au/au/journals/MULR/2006/7.html.

81) See also *Guidelines for End-of-life Care and Decision-making*, 2005, http://www.health.nsw.gov.au/pubs/2005/pdf/end_of_life_care.pdf; and *Using Advanced Care Directives (NSW)*, 2005, http://www.health.nsw.gov.au/policies/gl/2005/GL2005_056.html.

82) Advance Care Planning Fact Sheet, Department of Health and Human Services, Tasmania, 2009, http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0008/36935/Advance_Care_Planning_130509.pdf.

83) *Sayers v Harlow Urban District Council* [1958] 1 WLR 623.

84) *Hart v Herron* [1984] Aust Torts Reports 80-201, Fisher J.

85) *Herd v Weardale Steel Co* [1915] AC 67.

86) Lindsey P, *Violence and Aggression in the Workplace: A Practical Guide for all Health Care Staff*, Radcliffe Publishing, Oxford, 2006.

87) 'Decision-making tool: Responding to issues of restraint in aged care', Department of Health and Ageing, 2004, http://www.health.gov.au/internet/main/publishing.nsf/Content/AE6A3DEC50534D27CA256F4700752CFF/$File/decisiontool04.pdf.

Chapter 5

The contract of employment, including occupational health and safety and workers compensation

The contract of employment

Essentially, a contract is an agreement that gives rise to rights and obligations between the parties to the agreement, and such rights and obligations will be protected and enforced by the law. Most people enter into a wide variety of contracts every day of the week, ranging from simple contracts when purchasing goods from the local supermarket to the more complex contract when purchasing a new home. The principles of the law of contract also have application and importance for nurses and midwives in relation to the contract of employment between them and their employer.

The employer–employee relationship is based on the contract that is created between the two parties when the employer engages an employee to perform work under the employer's direction and control. Such a relatively simple statement is influenced and constrained by legislation and a range of legal principles as well as the administrative machinery that has been created to deal with issues that arise as a result of the contractual relationship.

An integral part of industrial law is industrial relations. This can be defined as the climate created within the legal framework of the contract of employment in order to achieve a harmonious working environment and maximum benefits to the employer and the employee at the workplace. Industrial relations is not a subject or area of concern that can be put into a compartment within an organisation and called upon as required. It has implications in every facet of an organisation's activities, because it is concerned not only with demands made in relation to wages and conditions of employment but with human interaction at the workplace. The ability of an organisation to create a working environment which is both harmonious and constructive for the employer and employee is largely determined by the degree of recognition given to the human factor and the individual as part of the organisation.

In any general consideration of industrial law and the employer–employee relationship, it is essential to keep in mind the distinction between an employee and an independent contractor. That distinction has been clearly spelled out in this text in relation to the doctrine of vicarious liability (see Chapter 3). The great majority

of nurses and midwives working throughout Australia are employees, but those nurses or midwives working as private duty nurses, homebirth midwives or, in some circumstances, agency nurses, are more often than not independent contractors. Any dispute on that threshold issue would have to be determined having regard to the facts and circumstances giving rise to the particular situation. Apart from the doctrine of vicarious liability, the major reason it is necessary to make the distinction between the two is that an independent contractor is unable to claim the benefits and conditions of an industrial award or workplace agreement and, in most cases, the statutory entitlements of long service leave, annual leave, parental leave and so on.

The legal principles relating to the formation of a contract of employment apply in exactly the same way as they do to the formation of any other contract. The following five conditions must exist:

1) There must be an offer and acceptance — in the contract of employment it is the employee who makes the employer an offer to work, which the employer can accept or reject.
2) There must be valuable consideration; that is, money or money's worth. In the contract of employment, the consideration is the exchange of services for money; that is, salary or wages, together with any other conditions that are agreed to apply.
3) There must be the intention to create a legal relationship. In the contract of employment, a person who volunteers to 'help out' in emergencies or other situations would not normally be deemed to be intending to create a legal relationship and therefore would not be an employee. Some exceptions may arise to that statement for workers compensation purposes, but not otherwise.
4) The parties must have the legal capacity to enter into the contract. In the contract of employment relating to nurses and midwives there is generally no difficulty on this issue. The issues that affect a person's legal capacity to enter into a contract may be briefly and primarily categorised at this point as:
   a) persons who are children;
   b) persons who are deemed to be mentally ill or suffer from a developmental disability; or
   c) drunkards or persons so affected by any other drug or substance as to be incapable of understanding the nature of the agreement.
5) The work to be performed must not be an unlawful act.

Terms and conditions of the contract of employment

An important part in establishing the contractual relationship is the necessity to determine the terms and conditions of the contract which have the effect of creating obligations on the parties to the contract. Some obligations in any contract of employment arise impliedly (or automatically) by the operation of long-established common-law principles; for example, an employee's obligation to obey all lawful and reasonable directions of an employer. Such obligations do not necessarily have to be written down in a contract for them to apply. In many instances, however,

such common-law obligations are often found embodied within contracts of employment.

For most employees, including nurses and midwives, the contract of employment is to be found within the award or agreement covering their place of work. The document may be referred to as an industrial award or enterprise agreement or workplace agreement.

There are also statutory provisions that complement the terms and conditions found in industrial awards or agreements. For example, an employer's obligation to provide a safe place of work is reaffirmed in occupational health and safety legislation in all states and territories as well as Commonwealth workplaces.

While most contracts of employment are in writing in one form or another, it is possible, though unusual, to create a legally binding contract of employment simply by verbal agreement between the employer and the employee. The reason why it is unusual is that the majority of employment situations are covered by an industrial award or written agreement of some kind.

THE EMPLOYEE'S OBLIGATIONS

In many instances, the employee's obligations may or may not be expressly spelled out in any contract of employment, be it an industrial agreement or otherwise. Nevertheless, if not expressly spelled out, they apply as implied conditions or obligations imposed on the employee in the contractual relationship with the employer and may be expressed as:

1) The employee has a duty to obey all lawful and reasonable directions of the employer. The significant words are 'lawful' and 'reasonable'. In most workplaces, many of the employer's lawful and reasonable commands are conveyed to the employee via written policies, procedures and protocols and the employee is required to comply with them. What would be reasonable would depend on the facts and circumstances of the situation under consideration.
2) The employee has a duty to display due care and diligence in the performance of his or her work and to perform it competently.
3) The employee has a duty to account to the employer for all moneys and property received in the course of employment.
4) The employee has a duty to make available to the employer any process or product invented by the employee in the course of employment.
5) The employee has a duty to disclose to the employer information received by the employee relevant to the employer's business.
6) The employee has a duty to be faithful and loyal to the employer's interests.
7) The employee has a duty to indemnify the employer for financial liability incurred by the employer on the employee's behalf under the doctrine of vicarious liability. As already explained in Chapter 3, this common-law duty is generally not enforced by the employer and, in New South Wales and South Australia as well as the Northern Territory and the Commonwealth, specific statutory provisions have been introduced to prohibit the employer from enforcing the employee's duty to indemnify.[1]

THE EMPLOYER'S OBLIGATIONS

Generally speaking, an employer's obligations have been almost totally reinforced by the creation of industrial agreements and by statute. The employer's obligations may be generally expressed as:

- the duty to pay salary or wages and provide any other conditions of employment agreed upon or expressly provided for by statute or otherwise;
- the duty to provide a safe system of work; and
- the duty not to discriminate against people in employment on various grounds such as sex, religion, race or disability.

Discrimination

Each of the states and territories as well as the Commonwealth has legislation that imposes a duty on employers not to discriminate against people in employment on various grounds such as sex, religion, race or disability. The respective states as well as the Commonwealth generally cover the same areas but some offer more extensive protection than others. The relevant legislation is as follows:

- Australian Capital Territory — *Discrimination Act 1991*: The employer is not to discriminate on the grounds of sex, sexual harassment, sexuality, transsexuality, age, profession, trade, occupation or calling, relationship status, status as a parent or carer, pregnancy, race, racial vilification, religious or political conviction, impairment, membership or non-membership of an industrial organisation, breastfeeding, spent convictions, disability and religious practice in employment.
- New South Wales — *Anti-Discrimination Act 1977*: The employer is not to discriminate on the grounds of race (including colour, nationality and national or ethnic origin), sex (including pregnancy), marital status, disability, homosexuality, age (compulsory retirement only), transgender and carer's responsibility. As well, conduct deemed unlawful includes sexual harassment and vilification of homosexuality, race, transgender and HIV/AIDS status.
- Northern Territory — *Anti-Discrimination Act*: The employer is not to discriminate on the grounds of race, sex, sexuality, age, marital status, pregnancy, parenthood, breastfeeding, impairment, trade union activity, religious belief or activity, political affiliation and irrelevant medical or criminal history.
- Queensland — *Anti-Discrimination Act 1991*: The employer is not to discriminate on the grounds of sex, relationship status, pregnancy, parental status, breastfeeding (goods and services only), race, age, physical impairment, religion, political belief or activity, trade union activity, lawful sexual activity, gender identity, sexuality and family responsibilities; sexual harassment is deemed unlawful conduct under the Act.
- South Australia — *Equal Opportunity Act 1984*: The employer is not to discriminate on the grounds of sex, sexuality, marital status, pregnancy, race,

age and physical and intellectual impairment (but does not include mental illness); sexual harassment is deemed unlawful conduct under the Act.

- Tasmania — *Anti-Discrimination Act 1998*: The employer is not to discriminate on the grounds of age, breastfeeding, disability, family responsibilities, gender, industrial activity, irrelevant criminal record or medical record, lawful sexual activity, marital status, relationship status, parental status, political activity, belief or affiliation, pregnancy, race, religious activity, belief or affiliation, sexual orientation, sexual harassment or inciting hatred on the basis of race, disability, sexual orientation or religion.
- Victoria — *Equal Opportunity Act 1995*: The employer is not to discriminate on the grounds of sex, sexual orientation, gender identity, pregnancy, breastfeeding, marital status, status as a carer, age, race (including colour, nationality, ethnic or national origin), parental status, physical features, childless or a de facto spouse, lawful religious or political belief or activity, impairment (including physical impairment, mental illness, mental retardation), industrial activity and lawful sexual activity and sexual harassment.
- Western Australia — *Equal Opportunity Act 1984*: The employer is not to discriminate on the grounds of sex, sexual orientation, marital status, pregnancy, race, religious or political conviction, age, racial harassment, impairment, family responsibility or family status, gender history and sexual harassment.
- The Commonwealth Government has a number of pieces of legislation dealing with discrimination overseen by the Australian Human Rights Commission. The relevant legislation is:
  - *Age Discrimination Act 2004*
  - *Australian Human Rights Commission Act 1986*
  - *Disability Discrimination Act 1992*
  - *Racial Discrimination Act 1975*
  - *Sex Discrimination Act 1984.*

Complaints made in relation to issues of discrimination are dealt with by the commission or board established under the legislation of each of the states and territories, and the Commonwealth. For example, in the Australian Capital Territory, there is a Discrimination Commissioner and New South Wales has the Anti-Discrimination Board. Queensland has an Anti-Discrimination Commission as does the Northern Territory. South Australia, Victoria and Western Australia have a Equal Opportunity Commissioner. If a complaint is unable to be successfully conciliated, it is generally referred to a tribunal for hearing and determination. If a complaint is made under the Commonwealth legislation, it is dealt with in the first instance by the Australian Human Rights Commission. If it is unable to be conciliated, the complaint may then be taken to the Federal Court of Australia or the Federal Magistrates Court.

The creation of an industrial award or workplace agreement

As already stated, one of the employer's obligations in the contract of employment is to pay wages and to provide any other conditions agreed upon between the employer and the employee or as provided by legislation. That obligation has, in most cases, long been embodied in industrial awards and/or agreements, the latter also known as enterprise agreements or workplace agreements. In some circumstances it may be an individual contract between the employer and the employee concerned.

Industrial awards or workplace agreements apply to almost 80 percent of employees in Australia. (People who are self-employed and professionals whose associations set their scale of fees do not belong in this category.)

As a statement of general application, an industrial award or workplace agreement is a document setting out the wages and conditions of employees who are employed in a particular industry or workplace and who are deemed to be covered by the particular document in question.

In Australia, the creation of industrial awards and workplace agreements has been overseen by industrial tribunals of the states, territories and the Commonwealth within the constraints of their respective constitutional powers and supported by an associated legislative framework.

Until relatively recent times, the majority of the states and territories had their own independent industrial tribunals to determine wage rates, together with conditions of employment and associated ancillary matters for employees working within state and territory-based industries. For example, in New South Wales, the Industrial Relations Commission exercised that power. In relation to Commonwealth employees and those employees who, as a general proposition, were employed in an industry that went beyond the borders of one state or territory, the Commonwealth's Australian Industrial Relations Commission (AIRC) did likewise.

Since 2006, much of that has been significantly altered as a result of the Commonwealth utilising the corporations power within the Constitution to assert its dominance over the states and territories in relation to the regulation of industrial relations in Australia. At that time, in a significant extension of its powers in relation to the legislative underpinning of industrial relations in Australia, the Commonwealth amended the then Commonwealth *Workplace Relations Act 1996* to insert into it what were generally known as the *WorkChoices amendments*.

The major changes effected by the new legislation were to expand the federal system of industrial regulation at the expense of the states and territories and, in doing so, to give employers greater freedom in the terms on which they could hire and fire workers. As well, all employees in Australia employed by what was described as a 'constitutional corporation' were to be covered by the WorkChoices amendments and therefore subject to the Commonwealth's industrial relations powers. As a result, the only employees exempted from the provisions of the WorkChoices amendments were state Crown employees, public sector employees in some states and territories and those people employed by unincorporated bodies such as small businesses.

In 2009, following a change of federal government, the Commonwealth replaced the *Workplace Relations Act 1996*, which incorporated the WorkChoices

amendments, with the *Fair Work Act 2009*. The provisions of the *Fair Work Act* applied from 1 January 2010 to all employees in the federal industrial relations system. The extended coverage of employees that had been a hallmark of the earlier WorkChoices amendments was retained. As well, the Commonwealth, with the exception of Western Australia, reached agreement with all of the states and territories for those states and territories to transfer to the Commonwealth their industrial relations powers so that employees who were employed by a small business that was not a 'constitutional corporation', as understood, would now be covered by the *Fair Work Act*. What that meant was that those employees employed by a small business that was not incorporated had their workplace terms and conditions transferred to Commonwealth legislative control under the *Fair Work Act 2009*. For those states with a state-based industrial tribunal structure, the only employees left for them to deal with were Crown employees and those public sector employees not already employed under a federal industrial award or agreement.

The major change established by the *Fair Work Act* was to identify National Employment Standards that are to be mandatory basic entitlements in all industrial awards or enterprise agreements. The standards identified are:

- maximum weekly hours of work;
- the right to request flexible working arrangements;
- parental leave and related entitlements;
- annual leave;
- personal/carer's leave and compassionate leave;
- community service leave;
- long service leave;
- public holidays;
- notice of termination and redundancy pay;
- provision of a Fair Work information statement, which details the rights and entitlements of employees under the new system and how to seek advice and assistance.

As well, the unfair dismissal rights of employees were amended. Under the previous WorkChoices amendments, employees working in a business with up to 100 employees could be dismissed for any reason without any right to challenge the dismissal. Under the *Fair Work Act*, an employee may file a claim for unfair dismissal if the employee has completed a minimum employment period of 12 months with a small business and 6 months in all other cases. A small business is defined as a business with fewer than 15 employees.

In relation to nurses and midwives, the situation varies as between the states and territories and as between nurses and midwives employed in the public sector and those employed in the private sector.

In New South Wales, nurses and midwives employed in the public sector continue to be covered by state industrial awards determined by the Industrial Relations Commission of that state. In all other states and territories, federal awards or agreements apply.

In relation to the private sector, in all states (including New South Wales) and territories, where the employer is a 'constitutional corporation', the Commonwealth's *Fair Work Act* applies. Healthcare industry employers in the private sector, be it private hospitals, nursing homes, medical centres or community-based care centres, are all invariably operating as corporations, which is the catalyst for invoking the Commonwealth *Fair Work Act* provisions. Accordingly, such nurses or midwives would be covered by the terms and conditions of a federal award or workplace agreement.

There would also be a number of nurses or midwives in the private sector, particularly in relatively small medical centres and/or general practice areas, who would be employed pursuant to a federally registered employment agreement.

Whatever the circumstances of employment are, a nurse or midwife should, at the commencement of employment, take steps to ascertain the nature of the employment contract and its terms and conditions. In most circumstances, particularly in the public sector, it will be an industry-wide award or enterprise agreement. In the private sector, it may be an agreement relating just to the individual hospital, nursing home or healthcare centre, or it may be an agreement relating to all staff employed in private hospitals or nursing homes owned and/or operated by an industry-wide corporation; for example, Hospitals Corporation of Australia in relation to private hospitals owned by that group, or the Uniting Church in the nursing home industry.

In all states and territories, advice about employment wage rates together with terms and conditions of employment can be obtained from the state or territory branch of the Australian Nursing Federation (known as the New South Wales Nurses' Association and the Queensland Nurses' Union in those states).

In addition to any role an industrial tribunal may have in the determination of industrial awards or workplace agreements, the industrial system is also called upon to deal with other industrial issues that arise out of the contract of employment. In general terms such industrial issues come about as a result of a disagreement or dispute that arises between the employer and the union on behalf of an individual employee or on behalf of all of the employees covered by a particular award or workplace agreement. Such disputation can arise for a variety of reasons; for example:

- disagreement over the proper interpretation of a provision in an award or workplace agreement;
- disciplinary measures implemented by the employer against an individual employee that are believed to be harsh and unreasonable — for example, termination of employment or demotion; and
- disagreement between the employer and employee about increases or changes in wages or conditions of employment.

On occasions, where agreement is unable to be reached, employees may go outside the formal industrial process and impose industrial action in the form of strikes, work bans and limitations in order to force the employer concerned to accede to employees' demands in relation to a particular matter. When that occurs, the employer will normally seek the intervention of the appropriate industrial

tribunal requesting that the employees concerned be ordered to return to work or lift bans. In such a situation, the industrial tribunal will endeavour to resolve the conflict between the parties by calling them together in proceedings known as a *compulsory conference*. At a compulsory conference the parties are encouraged to discuss the issues openly and frankly in an attempt to reach agreement. If that should fail a recommendation or order as to what should be done by both parties may be made.

How the contract of employment is terminated

All contracts that are entered into, whether they be contracts of employment or otherwise, ultimately come to an end either by the operation of law or by the actions of either party to the contract. As far as the contract of employment is concerned, there are a number of ways that employment will be deemed to have terminated. Once again, the common-law principles concerning the termination of employment have been modified by statute or by industrial awards. The situations that will give rise to a termination of the contract of employment are set out below.

A contract for a fixed period or a specific undertaking

A good example of a contract for a fixed period as far as a nurse or midwife is concerned would be where she or he was employed for the period of maternity leave. Once the contract period has expired, the contract is terminated. An example of employment for a specific undertaking might be where a nurse or midwife is employed for the duration of a research program. When the program is completed, the contract of employment is terminated.

Death

It is obvious that the employment contract is terminated on the death of an employee. Equally, if the employer is an individual, the employer's death will put an end to the contract. Where the employer is a company or government department or quasi-government authority, the death of a company director or department secretary does not affect the contract.

Transfer of business

At common law, a termination of employment is deemed to occur when one company transfers its business to another. However, legislation and award provisions have intervened in relation to this issue, particularly in relation to leave entitlements. In most situations, it is usually stated that service with the prior employer shall, on change of ownership of the business, transfer to the new owner for calculation of leave entitlements.

Frustration or impossibility of performance

The usual situation that arises under this heading is that the illness or incapacity of the employee is of such a nature and of such duration as to render an employee unable to perform his or her work and the obligation of the employee to perform under the contract is frustrated by the employee's prolonged ill-health. Obviously,

normal sick leave provisions and considerations are not contemplated here but rather a prolonged and seemingly continuing incapacity on the part of the employee to carry out the work for which the employee was engaged.

Consent

A contract of employment may be terminated by the mutual consent of both parties.

Redundancy

A contract of employment may be terminated because the position occupied by the employee is made redundant — generally because the employer is restructuring its business or where the business is being wound down. In such circumstances, an employee may be entitled to a redundancy payment. Entitlement to a redundancy payment is generally based on a week's or 2 weeks' pay for every full year of service with a maximum entitlement capped at a set number of weeks or months.

Generally, the employer has to offer a redundancy to an employee once the employee registers an interest in being made redundant but the employer generally cannot be compelled to offer a redundancy payment unless provision is made for the same in the award or workplace agreement. Under the *Fair Work Act* National Employment Standards, redundancy pay is one of the mandatory conditions of employment that must be provided for in awards and workplace agreements.

It is important to remember that in a redundancy, the position is deemed to be redundant, not the person who fills it.

Before offering a redundancy, an employer may offer alternative and financially comparable employment in order to ensure continuing employment and negate the need for a redundancy payment.

Termination by notice

If a period of notice is not expressly stated, the presumption is that a contract of employment may be terminated by reasonable notice of either party. Once again, statute and particular awards have modified this presumption so that all awards now state a specific period of notice which either party must give in order to terminate the contract of employment.

The period of notice required to be given can vary, but for most employers and employees the requisite period is 1 or 2 weeks.

The obvious exception to the necessity to give notice is where the employer has the right to summarily dismiss an employee on the grounds of misconduct. There is no general legal definition of misconduct as each case would have to be looked at in the light of its own particular facts and circumstances. The type of conduct that has, in the circumstances of each case, justified summary dismissal has ranged from:

- a wilful refusal by an employee to obey a lawful and reasonable direction from the employer;
- insubordination;
- breach of confidence in disclosing an employer's trade or other secrets;
- drunkenness affecting the employee's ability to work;

- fraud or dishonesty by the employee in his or her employment; and/or
- conviction of a crime, but only if the conduct constituting the crime is inconsistent with the proper performance of his or her duties as an employee.

Apart from circumstances that would warrant summary dismissal, there is still the right of the employer or the employee to terminate the contract between them. As far as the employer is concerned, that right has been constrained to some extent by the statutory power given to industrial tribunals to reinstate employees. The major factor that has to be established in asking an industrial tribunal to reinstate an employee is that the employee's dismissal is harsh and unfair. In other words, whatever the employee did or failed to do did not warrant the ultimate penalty of dismissal. In certain circumstances a tribunal may order compensation to the employee in lieu of reinstatement.

What constitutes an 'unfair' dismissal warranting reinstatement?

As always in such matters, there are no hard and fast principles that determine whether an employee has been treated fairly. Each case has to be judged on its own facts and circumstances and very rarely are two situations exactly the same. However, in arriving at a decision as to whether or not an employee has been treated fairly, the following factors would warrant consideration:

- The employee's length of service and previous conduct. Obviously an employee with many years of loyal and good service to the employer would warrant more favourable consideration than an employee with a short period of service and previous disciplinary problems.
- Has the employer clearly spelled out the duties and responsibilities expected of the employee? It may be that an employee's failure to perform a particular duty is due to the failure of the employer to inform the employee that the particular duty is expected of him or her, rather than the employee's refusal or inability to perform it.
- Has the employer drawn the alleged breach of duty to the employee's attention? Condonation by the employer of a course of conduct by an employee over a long period which the employer then uses to justify dismissal would not, in most situations, be sufficient to warrant dismissal.
- Once the alleged breach of duty has been drawn to the employee's attention, has he or she been given the opportunity to rectify the problem?
- Is there anything the employer could or should have done to rectify the problem? For example, it may be that an employee's excessive absences from work are due to domestic problems which may be able to be resolved with advice from the personnel department or staff counselling.
- If the employee's alleged breach of duty continues without good reason, the employer should firmly warn the employee in writing that his or her continued employment is in jeopardy and request an improvement.

- A further continuation of the alleged breach of duty on the part of the employee, without good reason, would normally be sufficient grounds to justify dismissal.

As long as the employer can show that the steps taken leading up to the employee's dismissal were fair and reasonable having regard to the employee's conduct, an industrial tribunal will not interfere with an employer's right to dismiss an employee.

As well as determining whether or not an employee has been treated fairly, an industrial tribunal is also concerned to ensure that, should an employee be reinstated, harmonious working conditions will prevail. Industrial tribunals are concerned with solving industrial disputes, not creating them. If it was thought that the reinstatement of a dismissed employee would create further industrial disruption at the workplace, an industrial tribunal would be reluctant to reinstate the employee even if it was established that the employee had been unfairly treated.

Workplace health and safety

In addition to the relevant occupational health and safety legislative provisions in place, workplace health and safety should be understood from three legal perspectives:

1) An employer's obligations to provide a safe place of work pursuant to the relevant occupational health and safety provisions. A breach of an employer's obligations to do so will render them liable to criminal prosecution for a breach of their occupational health and safety obligations and a significant financial penalty if the offence is found to be established.
2) The rights of an employee to claim compensation for work-related injuries. That right and subsequent entitlement arises under the relevant workers compensation legislation of each state and territory or, where applicable, the Commonwealth.
3) The right of an employee to claim monetary damages from an employer for personal injury arising from an employer's failure to provide a safe system of work.

This right is generally understood as arising from an employer's common-law obligation to provide a safe system of work and is considered and dealt with within the principles of common-law negligence as part of the law of torts. Given that the basis for any claim arises under the employment contract, there is a close interrelationship between any claim arising under workers compensation and a personal injury claim arising from an employer's negligence for a work-related injury. The major difference between the two is that in relation to workers compensation, in order to bring a claim, an employee is only required to establish that he or she sustained a work-related injury. In a personal injury claim for negligence, the employee would have to establish all the principles required to succeed in civil negligence, constrained as it now is by changes to civil liability law in each of the states and territories.

To further understand the principles of civil liability, with particular emphasis on professional negligence, reference should be made to Chapter 3.

Occupational health and safety legislation

Each of the states, territories and the Commonwealth have enshrined employer and employee obligations for the health and safety of people in a workplace within relevant legislation. While there is considerable similarity between the current respective legislative regimes, there are also differences. Those differences have created confusion and compliance issues, particularly for employers who have a business that operates across state and territory borders as well as Commonwealth instrumentalities. In 2008, the Commonwealth and the states and territories agreed to harmonise their occupational health and safety laws. In order to give effect to that agreement, the Commonwealth government passed and proclaimed the *Safe Work Act 2008*. The primary role of that Act was to establish a body called Safe Work Australia. The Commonwealth, all states and territories, as well as employer and employee representatives, had representation on the Members Group within Safe Work Australia. The task of Safe Work Australia was to prepare model occupational health and safety laws for adoption as a law of the Commonwealth and each of the states and territories.

After a comprehensive review of work health and safety laws across Australia, a draft *Work Health and Safety Act* was developed by Safe Work Australia and unanimously endorsed by the Members Group in December 2009. The intention was for all states and territories as well as the Commonwealth to pass the new laws encompassed within the model *Work Health and Safety Act* within a timeframe that would see the nationally harmonised laws take effect in all jurisdictions from 1 January 2012.

By the end of 2011, there had been mixed progress in ensuring the passage of the legislation in the respective states and territories. The Australian Capital Territory, New South Wales and Queensland have each enacted a new *Work Health and Safety Act* based on the agreed model legislation which took effect on 1 January 2012. Victoria and Western Australia have called on the Commonwealth to defer the implementation of the nationally harmonised occupational health and safety laws for 12 months. In doing so, the Victorian Government has reaffirmed its support for the principle of nationally harmonised occupational health and safety laws and the adoption of the agreed model Act. Western Australia has indicated its support for much of what is contained within the model laws but proposes to incorporate those changes into its existing legislation rather than adopt the model Act in its entirety. The Northern Territory, South Australia and Tasmania are proposing to have the model legislation in place but their respective parliaments have yet to pass the legislation.

Given the position adopted by Victoria and Western Australia, there has been some delay in reaching the intended objective of putting in place nationally harmonised laws in relation to occupational health and safety by the initially agreed timeframe of 1 January 2012. Until such time as that is achieved, each of the states and territories as well as the Commonwealth will continue to enforce their respective existing occupational health and safety laws.

The provisions contained in the model *Work Health and Safety Act* which is the template for the nationally harmonised legislative system are not significantly different from those currently applying in the respective occupational health and safety regimes of the states, territories and the Commonwealth in the general duties and obligations they impose on employers and employees. Given the intention of all of the parties to move to the proposed nationally harmonised laws, albeit with a slightly delayed timeframe, the intention in this text is to refer to the model *Work Health and Safety Act* that has been endorsed by all of the states, territories and the Commonwealth as representing the relevant law. Where states and territories have already passed the uniform laws, they have replicated the model *Work Health and Safety Act*. As a result, reference to a section of the model *Work Health and Safety Act* in this text has the same section number and content in the New South Wales *Work Health and Safety Act 2011* — likewise in the Australian Capital Territory and Queensland. It is envisaged that when the other states introduce the new laws they will adopt the same approach so that when the Act is in place in each state and territory, and the Commonwealth, it will have the same clause numbers. Regarding the insertion of variations in the various *Work Health and Safety Acts*, the agreement is that those variations will not change the clause numbering system of the Acts (with the possible exception of Western Australia). To date no state or territory has sought to vary the model Act when adopting it.

Duty of care owed by an 'employer' under the model *Work Health and Safety Act*

The model *Work Health and Safety Act* changes reference to the responsibilities of an 'employer' to the 'duty of care' owed by 'a person conducting a business or undertaking' (PCBU). A PCBU by definition (s 5 of the Act) includes an employer, corporation, association, partners in a partnership, sole trader and certain volunteer organisations (for example, a volunteer organisation that employs a person to carry out work is a PCBU, but a volunteer organisation that operates with volunteers and does not employ anyone is not a PCBU), and householders where there is an employment relationship between the householder and the worker.

The PCBU has the 'primary duty of care' under the Act (s 19). That person must ensure 'so far as is reasonably practicable' the health and safety of workers and 'other persons' (for example, customers or visitors) by removing or reducing risks from work being carried out as part of the person's business or undertaking. Such a duty encompasses, but is not limited to, a safe work environment, safe plant and equipment, safe systems of work, safe use, handling and storage of plant, structures and substances, provision of adequate facilities for the welfare at work of workers, information, training, instruction or supervision necessary to protect all persons at the workplace, and monitoring of workplace health to prevent illness or injury (s 19(3)).

There are also duties imposed on a PCBU who:

- manages or controls a workplace (s 20);
- controls fixtures, fittings or plants at a workplace (s 21);

- designs, manufactures, imports or supplies plants, substances or structures (ss 22–25);
- installs, constructs or commissions plants or structures for a workplace (s 26).

The duty imposed on all of the above categories of persons is to ensure 'so far as is reasonably practicable' that a workplace is safe and without risks to the health and safety of any person.

Clearly, central to the wide and general obligation placed on a PCBU to ensure a safe and healthy workplace 'so far as is reasonably practicable' is the obligation to identify and control risks to safety in the workplace. Risks to safety can occur at many levels in a workplace. For example, a piece of plant or equipment may be inherently unsafe because of inadequate guarding of dangerous parts, or the system of work adopted for a particular task may be unsafe because employees have not been given sufficient information, instruction, training and supervision to ensure the task is done safely and without risk to their health.

In order to address its workplace health and safety obligations in a proactive manner, a PCBU is required to approach the workplace from the perspective of identifying hazards and then undertaking risk analysis to determine how identified hazards can be eliminated or controlled.

Workplace hazards are many and varied and include:

- mechanical hazards relating to plant and equipment;
- chemical hazards such as toxic substances, flammable and explosive materials;
- environmental hazards such as dust and fibres from mining and agricultural activities;
- hazards associated with manual handling, weight lifting and occupational overuse syndrome;
- biological hazards including infectious diseases from animals or non-infectious allergic reactions from coming into contact with substances in the workplace.

WHAT IS MEANT BY 'REASONABLY PRACTICABLE'

The Act (s 18) defines 'reasonably practicable' as that which is, or was at a particular time, 'reasonably able to be done' taking into account and weighing up all relevant matters including:

a) the likelihood of the hazard or the risk concerned occurring;
b) the degree of harm that might result from the hazard or the risk;
c) what the person concerned knows, or ought reasonably to know, about:
   i) the hazard or the risk; and
   ii) ways of eliminating or minimising the risk; and
d) the availability and suitability of ways to eliminate the risk; and
e) after assessing the extent of the risk and the available ways of eliminating or minimising the risk, the cost associated with available ways of eliminating or minimising the risk, including whether the cost is grossly disproportionate to the risk.

DEFINITION AND DUTIES OF A 'WORKER' AND 'OTHERS' UNDER THE ACT

Under the Act an employee is included in the definition of 'worker'. The Act (s 7) defines a 'worker' as someone who carries out work for a PCBU. A 'worker' includes an employee, labour hire staff, volunteer, apprentice, work experience student, subcontractor and contractor. As well, a sole trader who is a PCBU and carries out work for another business (PCBU) is also a 'worker' for that PCBU.

The duties of a 'worker' (s 28) include that he or she must take reasonable care for their own safety and ensure that they do not adversely affect the health and safety of others. A 'worker' must also comply with any reasonable instruction and cooperate with the PCBU's work health and safety policies and procedures.

Under the Act, 'others' at a workplace include clients, customers and visitors. Their workplace responsibilities (s 29) are similar to those of a 'worker'. That is, they must take reasonable care for their own and others' health and safety and take reasonable care not to adversely affect the health and safety of others at the workplace. As well, they must comply with any reasonable instruction given by the PCBU, as far as they are reasonably able.

OBLIGATION ON A PCBU TO CONSULT WITH WORKERS

Consultation is a hallmark of the model Act. A duty is placed on a PCBU to consult with workers in relation to workplace health and safety 'so far as is reasonably practicable' (s 47). If there is a health and safety representative at the workplace he or she must be involved in the consultation (s 48(2)). Section 48 provides for the nature of the consultation that is to occur; that is:

- relevant information must be shared with workers;
- workers must be given a reasonable opportunity to express their views in relation to health and safety matters and be able to contribute to decision making;
- the views of workers are to be taken into account in relation to health and safety;
- the workers are to be advised on the outcome of consultation in a timely manner.

Consultation with workers is required in any of the following matters (s 49):

- identifying hazards and assessing risks to health and safety arising from the work carried out (or to be carried out) by the business or undertaking;
- making decisions about ways to remove or reduce those risks;
- making decisions about the adequacy of facilities for the welfare of workers;
- proposing changes that may affect the health or safety of workers;
- making decisions about the procedures for consulting with workers, resolving health and safety issues at the workplace, monitoring the health of workers, monitoring the conditions at any workplace under the management or control of the PCBU, and/or providing information and training for workers.

REQUIREMENT FOR WORKPLACE HEALTH AND SAFETY REPRESENTATIVE(S), WORK GROUPS AND HEALTH AND SAFETY COMMITTEES

Provision is made for workplace consultation to occur through workplace health and safety representative(s) (HSR), a work group and/or an occupational health and safety committee.

A worker or workers at a workplace may request that one or more HSRs be elected for the workplace (s 50). The number to be elected would obviously depend on the size and layout of the workplace and all of the workers at the workplace are eligible to stand for election and vote. As well, workers may request the establishment of work groups. The purpose of a work group (s 51) is to facilitate the representation of the workers in a work group by one or more HSRs. If a request is made by a worker or workers for the establishment of a work group, it is the responsibility of the PCBU to do all that is necessary to ensure the establishment of one or more work groups at the workplace (s 51). Work groups are to be established by negotiation and agreement between the PCBU and the workers or the representatives. Although the Act itself does not specify the circumstances that might give rise to the establishment of one or more work groups at a workplace, section 56(4) does state that the Regulations accompanying the Act 'may' prescribe matters that may be taken into account in negotiations and the establishment of work groups. Reference to regulation 16 of the Model Regulations provides that negotiations for and determination of work groups must be directed at ensuring the workers are grouped in such a way that most effectively and conveniently enables their health and safety concerns to be represented and that a HSR for a work group be 'readily accessible' to workers in the work group. Regulation 17 states that matters to be taken into account in determining the establishments of work groups in a workplace include the size and nature of the workplace, the diverse skill sets of the workers as well as work arrangements such as shift work.

The powers and functions of HSRs are considerable; to undertake the full range of their functions and powers HSRs are required to undergo training. He or she is to represent the workers in a work group in relation to workplace health and safety, monitor safety measures in the workplace, investigate complaints from workers in the work group relating to health and safety and inquire into risks to safety in the workplace. In undertaking those functions, a HSR may inspect a workplace, accompany an appointed Workplace Standards Inspector in his or her investigations in a workplace, be present at interviews with a worker relating to health and safety and receive information relating to the health and safety of workers in a relevant work group. A HSR can, where there is a serious risk to health and safety, direct a cessation of work (s 85) and may, in some circumstances, issue a Provisional Improvement Notice (PIN). Such a notice can require a PCBU to remedy a health and safety contravention, prevent a likely contravention, or take steps to remedy those matters causing the contravention.

An occupational health and safety committee must be established if requested by a HSR or five or more workers (s 75). The constitution of such a committee may be agreed by negotiation between the PCBU and the workers or their representatives (s 76). If there is a HSR in place, he or she must be on the committee. If there are two or more HSRs in a workplace, they are to choose one or more of them to be

on the committee. There must not be more than half of the committee representative of the PCBU. The functions of an occupational health and safety committee are essentially twofold — to facilitate cooperation between the PCBU and the workers in relation to health and safety issues at the workplace and to assist in the development of standards, rules and procedures for the workplace relating to health and safety (s 77).

Overall, the objective is to provide the workplace with an effective occupational health and safety management system that is acceptable to management and workers because it has had input from both.

The role of a workplace occupational health and safety committee is to act as an advisory body — to make recommendations and maintain a watching brief over occupational health and safety programs and their effectiveness. The committee itself is not responsible for occupational health and safety — the PCBU remains responsible for the health and safety of workers and others at all times.

Compliance provisions under workplace health and safety legislation

To ensure employers comply with their legislative obligations in relation to workplace safety, the legislation provides (s 156) for Workplace Inspectors to be appointed by the relevant state, territory or Commonwealth authority. Such persons have a general and specific authority to enter a workplace and, where necessary, enforce the relevant health and safety laws.

The overall functions and powers of Inspectors are to provide information and advice in relation to workplace health and safety, to assist in the resolution of health and safety issues at a workplace, to assist in the access of workplaces by HSRs and to deal with disputed right of entry issues in relation to authorised union officers. As well, they are empowered to review disputed Provisional Improvement Notices issued by HSRs, require compliance in relation to workplace health and safety matters by the PCBU by the issuing of notices, investigate contraventions of workplace safety, assist in prosecutions and attend coronial inquests relating to work-related deaths (s 160).

Inspectors are authorised under the Act (s 163) to enter workplaces without notice, and to take statements from individuals, photographs and copies of business records (s 165). They may even remove equipment. As well, they have the power to give legally binding directions by the issuing of notices as follows:

- prohibition notices mean that work must stop until the problem has been fixed (s 195);
- improvement notices mean that work can continue while the problem is being fixed (s 191);
- non-disturbance notices mean a workplace situation must not be disturbed while a matter is being investigated (s 198).

The Act also requires a PCBU to notify the relevant authority in each state or territory of any workplace accidents resulting in death or serious injury or a serious incident defined as a ‘notifiable incident’ (s 35). The notification must be done ‘immediately’ after the incident by ‘the fastest possible means’ (s 38).

Entry by an authorised union officer

In addition to workplace occupational health and safety committees or representatives, authorised union representatives are able to enter workplaces where they have members and investigate occupational health and safety matters. To do so, however, the union official must first possess a Work Health Safety (WHS) entry permit (s 117). To obtain such a permit, the officer's union must make application to the relevant nominated authority and the nominated union official must have completed prescribed health and safety training (s 131).

Holding a WHS entry permit allows the union official to enter a workplace where a contravention of workplace health and safety laws is suspected. When exercising a right of entry where a contravention is suspected, the WHS permit holder may inspect the workplace, consult with workers and the PCBU, take photographs, copy relevant documents and warn any person at the workplace of exposure to the risk to his or her health or safety (s 118).

The PCBU cannot obstruct a union official with a WHS entry permit in undertaking investigatory tasks in relation to occupational health and safety.

Penalties for non-compliance

The legislation provides for a regime of monetary penalties for a failure to comply with the recording and reporting requirements of the Act.

If a PCBU or an individual person is charged with an offence for a breach of their respective obligations under the workplace health and safety legislation, and the offence is proved according to the criminal standard, significant monetary penalties apply to the corporate body. For an individual found guilty of an offence under the Act, a period of imprisonment is provided for. The maximum penalty for the most serious offence by a corporation where death or serious injury has occurred, a Category 1 offence, is $3 million. If an individual who is a PCBU is found guilty of a Category 1 offence, the maximum penalty is a fine of $600 000 or 5 years imprisonment or both (s 31).

A comprehensive workplace health and safety system

Overall, to be effective, a proper approach to workplace health and safety should incorporate the following elements:

1) clear and comprehensive occupational health and safety policies and protocols — all policies and protocols should be regularly reviewed;
2) effective workplace communication and consultation;
3) adequate training and information to ensure workers know how to adequately protect themselves at work;
4) proper and adequate hazard identification and risk assessment;
5) risk control and management flowing from the risk assessment process; and
6) continuous reinforcement of the importance of workplace safety.

An issue of increasing concern to employers as part of providing a safe place of work in the health system is how to deal with the management of aggression and assault in the workplace. Healthcare staff, particularly nursing staff, can be, and

occasionally are, subject to verbal and physical assault by patients as well as relatives and friends of patients. This is a particular problem in accident and emergency units, psychiatric care areas, and nursing homes with a high proportion of residents with dementia. It is an issue that cannot be ignored by employers who should put in place effective policies and risk prevention strategies for dealing with the problem.

Workers compensation

Workers compensation is a form of statutory compensation that, subject to certain conditions, is available to an employee who is injured at work. The first workers compensation legislation emerged in Germany in the nineteenth century under Bismarck's administration. At different times earlier this century, all of the states, territories and the Commonwealth (with respect to Commonwealth employees) passed workers compensation legislation, based largely on the UK workers compensation legislation passed in the United Kingdom Parliament in 1906. Legislative change has taken place in each jurisdiction over recent years.

Workers compensation versus other types of compensation for injury at work

Workers compensation is but one of four entitlements which an employee may be able to claim when he or she suffers an injury at work. The other three entitlements are:

1) sick leave in accordance with the conditions set out in the relevant industrial award or workplace agreement;
2) social security payments, for example, disability pension, or unemployment benefits; and
3) compensation, in the form of damages, arising from an action in negligence against the employer and/or a third party alleging an unsafe system of work.

Recent legislative changes to workers compensation schemes in most states and territories, as well as civil liability claims, have placed restrictions on the rights of workers to make claims in relation to actions for work-related damages for negligence against an employer.

How does an employee qualify for workers compensation payments?

The three essential criteria that must be established to entitle a person to receive workers compensation are that:

1) the person must be a employee;
2) the person must suffer an injury or disease; and
3) the injury or disease must arise out of or in the course of employment, or the disease must occur in the course of employment and the employment must be a contributing factor or it must have contributed to a substantial degree.

Each of those criteria will now be further considered.

THE PERSON MUST BE AN EMPLOYEE

For the purposes of entitlement to workers compensation, the employment relationship of employer and employee must exist. Once again the major distinction that must be made here is that between an employee and an independent contractor. That distinction has been clearly spelled out in Chapter 3. Each of the relevant *Workers Compensation Acts* of the states and territories and the Commonwealth defines those persons who are eligible for workers compensation under the synonymous title of either 'workers', 'workmen' or 'employees'.

INJURY OR DISEASE

To be entitled to receive workers compensation payments the worker must suffer an injury which, as generally prescribed in the relevant legislation, arises out of or in the course of employment, or a disease that occurs in the course of employment and to which the employment was a contributing factor. In addition, the legislation generally provides for workers compensation to be paid to cover the aggravation, exacerbation, deterioration or general worsening of a disease process if the employment was a contributing factor or the employment contributed to a substantial degree.

Meaning of injury

The term 'injury' is generally interpreted in accordance with its ordinary everyday meaning; that is, it includes all damage sustained to the body as a result of any sort of trauma to the body including 'mental' injury. Apart from the 'physical blow' situation often associated with the concept of injury, conditions such as dermatitis, hepatitis and viral infections have been deemed to be injuries in that they all involve trauma to the body.

A good example of the broad view taken by the courts in relation to the meaning of 'injury' for workers compensation purposes was a case decided by the High Court of Australia in 1976. A worker had contracted viral meningeal-encephalitis and claimed workers compensation on the basis that the illness was an injury. The High Court decided that the illness was an injury within the ordinary meaning of the word. In coming to that decision, the then Chief Justice, Sir Garfield Barwick, said:

> The meningeal-encephalitis is neither idiopathic nor autogenous. It was the result of the introduction into the employee's body of a foreign body, the virus. The internal physiological change in the form of a developing meningeal-encephalitis was caused by the intruding virus. On this view this morbid condition of the body was not itself the relevant injury but merely the consequence of the introduction into the body from without of the virus, which though microscopic and innominate, was none the less substantial. This attack by, or reception of, the virus was the injury.[2]

Meaning of disease

In the case referred to above, the meaning of 'disease' was also canvassed. In making the distinction between 'injury' and 'disease' Sir Garfield Barwick stated that the word disease in its normal sense:

> … denotes a morbid condition of the body. It may be initiated by some external cause or be idiopathic or autogenous. Quite clearly when such a condition is idiopathic or autogenous, it will not qualify as an injury in the normal use of language.[3]

Essentially, disease, for the purposes of workers compensation, has been widely interpreted to cover a range of illnesses, such as heart disease, viral infections, cancer and epilepsy. The list is not exhaustive. A definition of disease is generally included in the workers compensation legislation of each state and territory and the Commonwealth.

On 15 May 1992, the then Chief Judge of the Compensation Court of New South Wales, McGrath J, gave judgment in a matter known only as *A v R* in which he found, on the balance of probability, that the applicant in that case had demonstrated that he acquired the HIV virus in the course of his employment as a first-aid officer.[4]

Briefly, the facts were that the applicant was diagnosed as being a sufferer of the disease of AIDS and he claimed that he acquired it by blood-to-blood infection in the course of conducting his duties as a first-aid officer. He claimed that, from time to time, he was required to treat open wounds which were bleeding and that, at such times, he was open to infection by reason of the fact that he was an inveterate nail biter who bit his nails down so far as to cause injury to his nail bed and surrounding parts of his fingers, causing frequent bleeding from those areas.

Depending on the definitions in the relevant workers compensation legislation, there are conditions that can be both an injury and a disease. For the purposes of workers compensation entitlements, it is necessary to establish not only that the disease was contracted in the course of employment, but also that the employment was a contributing factor in contracting the disease; with an injury, it is only necessary to establish that it arose out of the employment or occurred in the course of employment. Obviously, the latter phrase in relation to injury encompasses alternative criteria that must be established, and it is therefore only necessary for a worker to establish one or the other.

ARISING OUT OF OR IN THE COURSE OF EMPLOYMENT

The interpretation given by the various courts in recent years as to what constitutes 'arising out of or in the course of employment' has widened considerably in that the courts are accepting more and more activities as being work-related. As a general rule, the phrase 'arising out of employment' will be established where a worker can show 'that the fact of his being employed in the particular job caused, or to some material extent contributed to, the injury'.[5] Equally, the phrase 'in the course of employment' has been stated as meaning:

> … where a worker, while not performing the actual duties of his employment, was caused injury at a time and a place doing something which might be regarded as reasonably incidental to, consequential upon or ancillary to, his employment.[6]

Obviously, in determining either issue, if it were in dispute, the courts would have regard to the particular facts and circumstances of each case.

In most situations when a worker suffers injury at work there is no dispute that he or she is engaged in the course of employment. Other situations are not so clear, and generally require to be examined individually. As stated before, each situation must always be considered in the light of its own particular facts and circumstances, particularly when one has regard to the wide and variable interpretation given by the courts in such matters. The more obvious examples are set out under the headings that follow.

Travel to and from work

The workers compensation legislation has overturned the common-law principle that a worker travelling to or from work is not normally within the course of employment. The specific legislative provisions now state that travel between the place of employment and place of abode is considered to be within the course of employment. What is deemed to be 'place of employment' and 'place of abode' is usually defined in each Act. 'Journey claims', as such claims are called, are covered by the relevant provisions of the legislation and generally do so within the context of defining the terms 'place of abode' and 'place of employment' — the former term refers to the place where the worker resides for the purposes of travelling to and from work, while the latter term refers to the place where the worker undertakes his or her employment obligations. Problems can arise in establishing entitlement where a worker 'deviates' during his or her usual journey to and from work.

Injuries incurred during lunch periods or recognised rest periods

As a general rule, if a worker suffers an injury during a recognised lunch or recreation period which occurs on the employer's premises or in a situation which may be said to be incidental to the worker's employment, then the worker would be entitled to claim workers compensation. In a decision given in 1962, the High Court of Australia upheld a claim for workers compensation made by a worker who had been injured playing cricket during the lunch break, even though the employer had prohibited the playing of such games.

The employer had erected a sign prohibiting the playing of games in the lunch hour, but had never bothered to enforce the rule and for some 2 years, during the lunch break, workers had engaged in a variety of sports of which the employer was aware. When a worker was injured, the employer denied workers compensation payments on the basis that playing sport in the lunch period was not in the course of employment. In its decision in favour of the worker, the High Court said:

> … a worker who is having lunch on his employer's premises with his employer's sanction is, save in exceptional cases, 'doing something which he was reasonably required, expected or authorised to do in order to carry out his duties' … if this is to be said about taking lunch, why should not it also be said about taking a walk, dozing in the sun, or playing a game of table tennis or cricket …[7]

Injuries incurred while attending trade schools, seminars and so on

Workers who are required to attend a trade or training school as part of their contract of employment and who are injured while attending or while travelling to or from the school would clearly be in the course of employment. Equally, employees sent away on seminars, conventions, conferences and so on would normally be said to be acting within the course of employment.

Injuries incurred as a result of being assaulted at work

If a worker is carrying out duties or activities related to his or her employment and he or she is assaulted, the worker is clearly acting in the course of employment and is entitled to workers compensation payments. Accordingly, a nurse or midwife who, while carrying out his or her duties, is attacked and injured by a patient is clearly in the course of employment. However, a worker who is injured on the employer's premises as a result of an assault by another person would not be entitled to claim workers compensation unless that worker was carrying out duties or activities related to his or her employment. An example of the latter situation occurred in the case of *Bill Williams Pty Ltd v Williams*.[8] The relevant facts of the matter are set out below.

Williams was the managing director of a company and on one occasion when he was at work on the company's premises he was approached by a man named O'Neill who made allegations that Williams was having an affair with O'Neill's wife. An argument ensued between them and Williams assaulted O'Neill. O'Neill had a rifle and threatened to shoot Williams. Williams ran out of the premises. O'Neill followed and shot him in the back. Williams later claimed workers compensation payments for the injuries received.

The court rejected his claim on the basis that while Williams was clearly within the course of employment during the time he was on the employer's premises, the argument with O'Neill was unrelated to his employment and had interrupted the course of employment.

Injuries incurred whilst participating in sporting activities generally

There can be no hard and fast rule in relation to this area. Many employers actively encourage their employees to participate in competitive sport or in sporting teams associated with the employer. As a general rule it could be said that an employee who is participating in a sporting activity is not acting within the course of his or her employment, even where the employer actively encourages such participation. However, where an employee, as part of his or her contract of employment, is expected to participate in sporting activities or does so with the express approval of the employer and is paid while doing so, then the employee could be said to be acting in the course of his or her employment and be entitled to claim workers compensation. Similarly, participation in social activities, work picnics and the like must be considered on the facts of each case.

Defences to a claim for workers compensation

It is no defence to a claim for compensation for an employer to say that the worker was the author of his or her own misfortune. It does not matter in workers

compensation claims that the worker may have been negligent. It is, however, a defence if the employer can show that the injury was caused by the worker's own serious and wilful misconduct.

Making a workers compensation claim

If in doubt, always seek legal advice as to your entitlement to workers compensation. If you are a member of the relevant union in your state or territory, they will always provide you with advice and assist you with making a claim. The following points should be borne in mind:

- Time limits for making a claim — different provisions apply in respect to the giving of notice of injury or disease and, in some cases, the making of a claim for compensation.
- Incapacity and the payment of benefits — workers compensation benefits will be paid when the injury or disease sustained by a worker in relation to his or her employment results in the worker's incapacity for work. Incapacity for work can be either total or partial and is deemed to arise when the injury or disease prevents an employee from:
  - performing the full range of his or her employment duties; or
  - obtaining other employment.
- *Total incapacity* is where the injury or disease prevents the employee from performing all of his or her pre-injury employment duties.
- *Partial incapacity* is where the injury or disease prevents the employee from performing some, but not all, of his or her pre-injury employment duties. For example, when a nurse suffers a work-related back injury, the nurse is often told he or she can return to work as long as he or she performs only 'light duties', which usually means no heavy lifting or excessive bending. Whether or not the employer can provide such work and the rate of pay the nurse may be able to earn as a result of the partial incapacity is significant for the purposes of determining the nurse's workers compensation entitlements.
- Workers compensation payments can be made on a weekly or lump sum basis and may be made to either the worker or the dependants of a deceased worker.
- Additional payments that may be made to cover costs arising from a workers compensation injury will include such matters as:
  - medical expenses, including artificial aids such as limb prosthesis, false teeth and so on;
  - alterations to the injured worker's home necessitated by the long-term effects of the injury, such as ramps or handrails;
  - the cost of rehabilitation and/or the need to provide domestic assistance; and
  - funeral expenses.

Some practical considerations and advice concerning workers compensation

- Any injury suffered at work, no matter how slight it may appear, should be recorded and reported. Even apparently minor injuries can give rise to unforeseen consequences. The procedure for recording is a matter for individual hospital policy. It may be an accident report book at local level or an accident report form sent to central administration.
- Statistical reports of injuries received at the workplace should be used by the employer as a guide in the implementation of occupational health and safety measures at the workplace.
- Some work-related injuries, particularly back injuries, occur gradually over a long period of time. Nurses are often inclined to treat mild back pain themselves by staying home from work for one or two days. As most employers do not require a medical certificate for up to 2 days' sick leave, no medical attention is sought. As a result, the leave taken is recorded as sick leave and the nurse's sick leave record is reduced. Accordingly, no report is given to the employer of the work-related back pain and no record is made of that fact on the nurse's file. In due course the injury is diagnosed and long periods off work and/or surgery are required. The question then arises as to how the injury occurred and when it was reported. In summation:
  - do not treat a work-related injury by yourself;
  - report and record all instances of work-related pain — particularly back pain;
  - ensure that all time taken off with work-related injuries is claimed as workers compensation leave and not sick leave. If sick leave is initially debited for a workers compensation injury it should be re-credited by the employer when the workers compensation is paid.
- On occasions a worker may be off work for many months with a workers compensation injury. If there is no likelihood of the worker's return to work after a reasonable period of time, the employer may decide to terminate the worker's employment. Most employers wait until the expiration of the period of full pay before making any decision in that regard. In some of the recent legislative changes in this area, restrictions have been placed on the right of the employer to terminate the employment of a worker following a workers compensation injury.
- On occasions an employer will ask a worker to resign if it appears that the worker is unlikely to return to work in the foreseeable future. As a rule, a worker should not resign but wait for the employer to terminate the employment.
- When recovering from a work-related injury a worker is often advised by his or her medical practitioner that he or she is fit for 'light duties' which means the worker is partially, but not fully, incapacitated. The worker knows that the employer has no work which can be considered light duties. Nevertheless the worker should present such a certificate to the employer. In some instances

the employer's inability to provide light duties may mean that the worker is deemed to be totally incapacitated.

- Termination of employment because of a workers compensation injury will not terminate the worker's entitlement to continue to receive workers compensation payments. Such payments will continue as long as the incapacity to work continues and as determined by the medical evidence.

If in any doubt concerning a workers compensation entitlement, always seek advice from the appropriate organisation in your state or territory.

Safe system of work

In addition to an employer's obligations under occupational health and safety legislation, with its potential for criminal penalties, an employer may be found liable to an employee for monetary damages where an employee could establish that he or she suffered a work-related personal injury as a result of the employer failing to provide a safe system of work.

An entitlement to bring such a claim is in addition to any claim for workers compensation an employee may have for a work-related injury. The difference between the two potential claims is that a claim for damages based on an unsafe system of work requires the employee to prove to the requisite standard all of the legal elements required to ground such a claim in civil negligence.

A claim for workers compensation is more straightforward. It requires a claimant to establish he or she was an employee at the time of the injury and that the injury arose out of or in the course of employment. Such a claim is often easier to establish than one based on civil negligence.

There is nothing to preclude an employee bringing both a workers compensation claim and a claim for damages based on an unsafe system of work allegation. However, if both proceed and monies are paid under both claims, the money paid in workers compensation is offset against any monies paid for personal injury damages.

Any claim for personal injury damages based on an unsafe system of work would need to be pursued as a claim in civil negligence by establishing the legal principles discussed in Chapter 3. As well, such a claim would be subject to the threshold requirement of having to show, as a result of the work-related injury arising from the employer's negligence, that the worker suffered a 15 percent whole person impairment that can be medically established.

An unsafe system of work can take many forms. In the first instance it is necessary to understand the nature of the duty of care owed by an employer to the employees. This principle is precisely stated in the decision of the High Court of Australia in *Rae v Broken Hill Proprietary Co Ltd*.[9] The facts of the appeal do not need to be stated. The relevant passage of the decision is as follows:

> The question always is whether an employee's injury has resulted from some failure on the part of the employer to take reasonable care for the safety of the former. Such a failure may be shown by establishing, in appropriate cases, a failure to observe commonly recognised precautions or safeguards

> or, in others, by showing that the performance of his work by an employee has exposed him to risk of injury which might reasonably have been foreseen and avoided.[10]

As far as nursing and midwifery staff are concerned, the situations that may give rise to an allegation of an unsafe system of work and that may cause them to suffer significant damage can vary from workplace to workplace. Some examples could be:

1) failure to provide for the proper 'trapping' and control of anaesthetic gases in operating theatres;
2) failure to properly earth and maintain all electrical equipment used by staff;
3) failure to provide proper instruction, lifting equipment or appropriate staff in the lifting or care of patients; and
4) failure to reasonably and adequately protect staff against the transmission of infectious diseases such as hepatitis.

The example given in item 3 above is probably the most contentious area as far as injuries to nursing and midwifery staff are concerned. There is no doubt that back injuries constitute a large percentage of injuries suffered by them in the course of their employment. In most situations the person concerned will claim and be paid workers compensation. It is arguable, in some instances, and depending on the facts and circumstances, the nurse or midwife may also have the right to bring an action in civil negligence alleging an unsafe system of work.

In determining what is a reasonable standard having regard to a safe system of work, the following factors should be borne in mind:

- the degree of likelihood of harm occurring in relation to a particular procedure or incident;
- the steps taken to reduce the likelihood of harm in relation to a particular procedure or incident; for example, in the lifting of patients the following points are worth noting:
  - adequate and proper instructions for lifting patients;
  - adequate lifting devices as circumstances warrant;
  - working facilities built to accommodate difficulties in lifting; for example, bathrooms may need structural alterations to allow patients to be lifted in and out of the bath without undue difficulty;
  - adequate instructions to staff about procedures to be followed if difficulties arise; and
  - adequate additional staff, such as wards people, available as circumstances require;
- any failure on the part of the employer to take all reasonable steps to eliminate the likelihood of the harm occurring;
- any failure on the part of the employee to take all reasonable steps to prevent being injured.

Endnotes

1) Commonwealth: *Insurance Contracts Act 1984* s 66; NSW: *Employees Liability Act 1991* ss 3 and 5; NT: *Law Reform (Miscellaneous Provisions) Act 1984* s 22A; SA: *Civil Liability Act 1936* s 59.
2) *Favelle Mort v Murray* (1976) 8 ALR 649 at 652.
3) Ibid.
4) *A v R* (Compensation Court of New South Wales, McGrath J, 15 May 1992, unreported).
5) *Nunan v Cockatoo Docks* (1941) 41 SR (NSW) 119 at 124.
6) *Hickox v Education Department* [1974] VR 426 at 430.
7) *Commonwealth v Oliver* (1962) 107 CLR 353 at 363.
8) *Bill Williams Pty Ltd v Williams* (1972) 126 CLR 146.
9) *Rae v Broken Hill Proprietary Co Ltd* (1957) 97 CLR 419.
10) Ibid, at 430.

This page intentionally left blank

Chapter 6

The administration of drugs

In 2009 the Australian Pharmaceutical Benefits Scheme (PBS), the means by which the Australian Government subsidises prescription medication in Australia, was costing the tax payer over $8 billion per year. However, this equates to just over 14 percent of total government expenditure on healthcare, and less than 8 percent of the cost of the total health system.[1] In addition, many medicines are purchased over the counter without a prescription and these include analgesics (pain-killers), cough medicine, vitamins and complementary medications. In Australia hospital admissions associated with adverse drug events range from 5.6 percent in the general population to 30.4 percent of admissions in the elderly, and 3.3 percent of the time admissions are paediatric emergency department attendances reported to be associated with adverse drug events.[2]

The great majority of medications that nurses and midwives administer on a day-to-day basis are considered to be, and are defined by legislation as, poisons. That is, generally speaking, they are substances that, by their very nature, are inherently dangerous to one's health if not used appropriately. Accordingly, it is considered necessary to identify them and lay down clear provisions as to how such substances may be obtained, the basis on which a person may have possession of them, who may prescribe them, how they must be stored, and so on.

The Commonwealth, as well as each state and territory of Australia, has specific legislation which covers the control and supply of poisons and therapeutic goods in that state or territory.[3] This is set out in Appendix A to this chapter.[4] Amongst other things, that legislation sets out the specific responsibilities of nurses and midwives in relation to the various types of drugs that they have to deal with and administer in their work. The possibility of making drug-related errors, and the legal consequences that can flow from this, are such that nurses and midwives need to be aware not only of specific legislative requirements that apply to them, but also how to minimise the possibility of errors occurring.

The information contained in this chapter will be of value to registered nurses and midwives and also enrolled nurses. In the past, only registered nurses and midwives were allowed to administer medications against a prescription. However, over the past 10 years new programs have been developed for enrolled nurses across

Australia to enable them to administer medications. At the time of writing all enrolled nurses are presumed to be medication-endorsed under the new national registration scheme. Enrolled nurses who are not medication-endorsed are expected to advise the Nursing and Midwifery Board of Australia (NMBA) so that a notation can be put against their registration to advise employers and the general public that they are not able to administer medications. This notation provides protection not only for the public, but also for the enrolled nurse, as it ensures they are not expected to deliver care outside of their scope of practice. If an enrolled nurse who is not medication-endorsed completes a required program of study they are able to apply to the NMBA to have the notation lifted from their registration.[5]

The legislation that governs the management of medication has different titles in the different jurisdictions and these are set out in Appendix A of this chapter. Not only are there statutes that govern the control of drugs, there are very specific regulations and orders that set out exactly how medications must be managed and the degree of control to which specific medications and drugs are subject. The legislation embraces all conceivable types of poisons available, ranging from agricultural poisons and domestic pesticides to drugs of addiction. The relevant legislation in each state and territory is relatively similar in the way in which it classifies and identifies poisons and therapeutic goods but there are differences in the detailed provisions that apply in some areas. In addition, as part of these various statutes, certain criminal offences are indicated where a person deals with certain poisons in a manner contrary to the provisions, particularly the drugs of addiction. Criminal charges in relation to well-publicised drug offences, such as possession or supply of heroin or cocaine, arise under other legislation.

For the sake of clarity and because of varying legal requirements, the types of poisons or drugs available are divided into various sections, or schedules, which are determined by the Poisons Standard (currently Poisons Standard 2011) established under paragraph 52D(2)(b) of the *Therapeutic Goods Act 1989* (Cth). Such provisions are then incorporated into the various statutes in each jurisdiction. For legal definitions, it is still necessary to check with each relevant state or territory authority but the Standard for the Uniform Scheduling of Medicines and Poisons No 1 (the SUSMP 1) provides the template for each jurisdiction.[6]

The schedules of poisons are set out in the SUSMP 1 and a comprehensive list of the poisons that are identified within each schedule follows. The information in the SUSMP 1 points out that poisons are not scheduled on the basis of a universal scale of toxicity. Although toxicity is one of the factors considered, and itself incorporates a complex set of factors, the decision to include a substance in a particular schedule also takes into account many other criteria such as the purpose of use, potential for abuse, safety in use and the need for the substance. The SUSMP 1 now lists poisons in nine schedules according to the degree of control recommended to be exercised over their availability to the public. The types of poisons in each schedule are set out in Table 6.1.

The specific schedules that are most relevant to nursing staff are those generally identified as Schedule 4 substances and Schedule 8 substances. Schedule 4 substances are commonly referred to as 'prescription only' or restricted substances and cover all drugs that are able and required to be provided on the prescription of

Table 6.1 Schedules of poisons under SUSMP 1	
Schedule 1.	This Schedule is intentionally blank.
Schedule 2.	**Pharmacy Medicine** — Substances, the safe use of which may require advice from a pharmacist and which should be available from a pharmacy or, where a pharmacy service is not available, from a licensed person.
Schedule 3.	**Pharmacist Only Medicine** — Substances, the safe use of which requires professional advice but which should be available to the public from a pharmacist without a prescription.
Schedule 4.	**Prescription Only Medicine,** or **Prescription Animal Remedy** — Substances, the use or supply of which should be by or on the order of persons permitted by state or territory legislation to prescribe and should be available from a pharmacist on prescription.
Schedule 5.	**Caution** — Substances with a low potential for causing harm, the extent of which can be reduced through the use of appropriate packaging with simple warnings and safety directions on the label.
Schedule 6.	**Poison** — Substances with a moderate potential for causing harm, the extent of which can be reduced through the use of distinctive packaging with strong warnings and safety directions on the label.
Schedule 7.	**Dangerous Poison** — Substances with a high potential for causing harm at low exposure and which require special precautions during manufacture, handling or use. These poisons should be available only to specialised or authorised users who have the skills necessary to handle them safely. Special regulations restricting their availability, possession, storage or use may apply.
Schedule 8.	**Controlled Drug** — Substances which should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence.
Schedule 9.	**Prohibited Substance** — Substances which may be abused or misused, the manufacture, possession, sale or use of which should be prohibited by law except when required for medical or scientific research, or for analytical, teaching or training purposes with approval of Commonwealth and/or state or territory health authorities.

a medical practitioner, nurse practitioner, eligible midwife, dentist or veterinary surgeon. Schedule 8 substances are called 'controlled drugs' and sometimes 'drugs of addiction'. Apart from the Schedule 8 drugs, there are few drugs that nurses or midwives administer on a day-to-day basis that do not come within Schedule 4. For example, such drugs as antibiotics, antihypertensives and anticoagulants clearly fall into Schedule 4, as they can be obtained only on prescription.

In some jurisdictions certain drugs are declared to be Schedule 4 substances but in terms of storage and security are required to be dealt with in the same manner as Schedule 8 substances. As an example, the substances set out in Appendix D of the *Poisons and Therapeutic Goods Regulation 2008* (NSW) include barbiturates, benzodiazepines and pseudoephedrine. While Schedule 8 substances are commonly referred to as controlled drugs, in New South Wales they are known as drugs of addiction, (sometimes) in Tasmania as narcotic substances, and in Western Australia, drugs of dependence. Whatever the minor variation in titles, the type of drugs that come within this Schedule are usually the narcotic analgesics

such as opium, opium derivatives (morphine) and synthetic opium derivatives (pethidine).

Some substances that nurses and midwives administer from time to time are not required to be provided on prescription. They are often referred to as 'nurse- or midwife-initiated medications' and can be administered by nursing or midwifery staff without a medical officer's authority or prescription. These medications usually include substances such as antacids, aperients and paracetamol. Nurses and midwives should not automatically assume their right to administer such substances without reference, and should do so only in accordance with clearly written guidelines drawn up by the hospital or health authority.[7]

The specific list of drugs under the various schedules changes fairly frequently as new drugs are developed and introduced. It is therefore essential that nurses and midwives be aware of this aspect and that any relevant addition or change to the list of drugs in Schedule 4 or Schedule 8 be communicated to them. Hospitals are automatically notified of relevant changes to the poisons legislation by the state or territory health departments, generally by way of departmental circulars. To the extent that they are relevant, such circulars should be acted upon where necessary and distributed to all staff concerned.

Examining the relevant Regulations

As we have already indicated, the various state and territory Acts and the division of the schedules are essentially similar in fundamental layout and content and it is not intended to incorporate the precise details of each state or territory's legislative provisions in this text. The Regulations that accompany each of the Acts, and which are extremely important to nurses and midwives, vary in the precise words used concerning requirements as to the authority to prescribe, possess, control, supply, store and so on, but not to any significant degree. Some Regulations are more precise and detailed than others, and nurses in each state and territory should read their relevant Regulations carefully. When doing so, it is important to note the distinction between the words 'prescribe', 'dispense' and 'administer' — that is, in general terms, medical and nurse practitioners and eligible midwives (and others) prescribe, pharmacists dispense and nurses and midwives (and others) administer. The degree of commonality in the various state and territory Regulations can best be summarised as follows.

Schedule 4: restricted substances

As a general rule, only medical and nurse practitioners, eligible midwives, dentists and veterinary surgeons can issue a prescription for a restricted substance. Prescriptions are required to contain specific details, such as the name and address of the patient, date, drug and dosage. Some states and territories require that the prescriber shall write 'legibly' although this may be overcome with electronic prescribing. In an emergency, a medical practitioner can direct the dispensing of a restricted substance orally, including by telephone, subject to certain requirements.

Except in hospitals, no person other than a pharmacist or a pharmacist's assistant can dispense a prescription for a restricted substance. In hospitals where

a pharmacist is employed, he or she is responsible for the storage and recording of restricted substances. In hospitals where no pharmacist is employed, the director of nursing or, in his or her absence, the person acting in the position, or the medical superintendent, has the responsibility for such storage and recording. More often than not, in remote areas, such a task falls to the registered nurse in charge because there is no medical practitioner on the premises.[8] Whoever is responsible for the storage and supply of restricted substances must not issue such a substance from hospital stocks unless he or she has a proper prescription or the appropriate ward requisition slip from the nurse in charge of the ward.

Restricted substances can be administered in hospitals only on the written authority of a medical or nurse practitioner or an eligible midwife, except in the case of an 'emergency', when the medical or nurse practitioner or eligible midwife may verbally authorise the administration of a restricted substance. If the medical or nurse practitioner or eligible midwife verbally authorises the administration of such a substance he or she must confirm that verbal authority generally within 24 to 48 hours by writing in the patient's notes.

Schedule 8: controlled substances

Certain persons are authorised to be in possession of and supply certain drugs of addiction for the purposes of their profession or employment. Such persons include:

- a pharmacist;
- a medical practitioner;
- the director of nursing of a public hospital where no pharmacist is employed, or, in the pharmacist's absence, the person acting in the position;
- the nurse or midwife in charge of a ward in a public hospital;
- a nurse or midwife employed in a community health centre;
- a nurse employed in air ambulance duties; or
- a director of nursing and/or midwifery of a private hospital or nursing home.

It is important to remember that where a nurse or midwife, or any other person for that matter, is given authority to be 'in possession and supply' of drugs of addiction, provision is also made for such authority to be withdrawn if it is breached or exceeded.

Only a medical or nurse practitioner, eligible midwife, dentist or veterinary surgeon can issue a prescription for a drug of addiction. The requirements for such prescriptions are similar to those for restricted substances. In an emergency a medical or nurse practitioner or eligible midwife can direct the dispensing of a drug of addiction orally, including by telephone, subject to certain requirements. Except in hospitals, no person other than a pharmacist or a pharmacist's assistant can dispense a prescription for a Schedule 8 drug.

The nurse or midwife in charge of a ward is required to keep all drugs of addiction stored separately from other goods, with the exception of certain restricted

substances. The storage area should be a separate receptacle or cupboard securely fixed to the premises and it should be kept securely locked when not in use. Any person, including a nurse or midwife, authorised to be in possession of and supply drugs of addiction is to keep the safe or cupboard in which they are stored securely locked and is to keep the key on his or her person. If the authorised person is absent from the premises the key to the cupboard or safe should not be left lying around.

Approval can be given by state or territory health authorities for drugs of addiction to be kept in approved first-aid kits for use in an emergency in isolated localities, in an occupational health centre, in search and rescue operations or in other approved situations. In such approved situations a register must be kept.

The requirements for the storage of drugs in hospitals and health services are all similar to those set out in the South Australian Department of Health's *Code of Practice for the Storage and Transport of Drugs of Dependence*, the relevant sections of which are set out below in Box 6.1.[9]

Ward registers or drugs books

There is also a requirement with controlled substances that the nurse in charge of a hospital ward will keep a register of controlled drugs (a 'ward register') in that ward. For example, under section 101(1) of the *Health (Drugs and Poisons) Regulation 1996* (Qld), the ward drugs book is required to record information about obtaining controlled drugs into the unit from the central storage point and administering controlled drugs to persons in the unit. The person in charge is expected to ensure that the ward drugs book is bound and sequentially numbered, relates only to one class of controlled drug, has a heading describing the class of controlled drug and records in the measurement unit the quantities of the drug involved in a transaction.

If any drug of addiction is lost, destroyed or rendered unusable, a person authorised to possess such drugs must be notified. In the case of a drug of addiction that is unusable and has to be destroyed, the destruction of the drug must be undertaken by the pharmacist, director of nursing or medical superintendent in the presence of another person and a record made in the register of such loss or destruction. Where an ampoule of a drug of addiction is only 'part used' and the remainder discarded, the entry in the register should record that fact. For example, if a patient is ordered 75 mg of pethidine and the only ampoules available are 100 mg ampoules, the register should record that the patient received 75 mg and the remaining 25 mg was destroyed on the basis that it had been rendered unusable.

In some jurisdictions there are specific requirements concerning the responsibilities of the nurse in charge of a private hospital or nursing home. These do not differ in any significant degree from the requirements already mentioned, except to the extent of limiting the quantities of drugs of addiction that person is authorised to possess.

The relevant Regulations usually specify what a nurse should do if there is a discrepancy or there are missing drugs. This usually requires notification to a relevant person or body. The process for such notification should also be spelled out in the employer's policy and procedure manual.

BOX 6.1
SOUTH AUSTRALIA DEPARTMENT OF HEALTH'S CODE OF PRACTICE FOR THE STORAGE AND TRANSPORT OF DRUGS OF DEPENDENCE

Health service and surgery

4) All drugs of dependence stored in a health service, ward, day surgery unit, or medical, dental or veterinary surgery, must be placed in a securely locked storage cabinet that meets or exceeds the following requirements:

4.1) Where the quantity of drugs stored is not more than 15 doses—

4.1.1) made of 15mm thick hardwood; and

4.1.2) fitted with a 5 lever key lock or equivalent locking mechanism; and

4.1.3) securely fixed to the wall or floor; or

4.2) where the quantity of drugs stored is more than 15 doses and the immediate area in which the cabinet is situated is supervised at all times, the requirements specified in sub-paragraphs 4.1.1 to 4.1.3 above; or

4.3) where the quantity of drugs stored is more than 15 doses and the immediate area in which the cabinet is situated is not supervised at all times (eg nights) the requirements of Australia/New Zealand Standard for Safes and Strongrooms (AS/NZS 3809:1998) Resistance Grade 1; or

4.4) as approved by the Director, Pharmaceutical Services.

Restricted access

5) No person other than an authorised person shall have a key to the cabinet.

5.1) At all times, while on duty, the authorised person for the time being in charge of a ward, medical, dental or veterinary surgery, day surgery unit or nursing home must keep the key to the cabinet in his or her control and possession.

5.2) Where the key is a combination, PIN or password it must not be divulged to any unauthorised person. Combinations and passwords must be changed at regular intervals and de-activated when a person having knowledge of the combination or password ceases employment at the hospital, surgery or nursing home.

5.3) No person other than an authorised person shall lock or unlock the cabinet or remove or add to or in any way interfere with drugs in the cabinet.

5.4) The cabinet must only be unlocked for the purposes of:

5.4.1) the storage of drugs;

5.4.2) supply, administration or destruction of a drug; or

5.4.3) the examination and counting of drugs for audit purposes.

5.5) The cabinet must be re-locked immediately after use.

Problem areas with drugs

Although a sound knowledge of the relevant legislation relating to drugs and poisons is essential for nurses and midwives, what is equally as important is an awareness of the problem areas in relation to drugs and how to avoid and/or deal with them. Mistakes can and do occur and it is unlikely that any system devised will ever entirely eliminate the probability of drug-related errors occurring in the future. Hospital administrators, medical practitioners, nurses and midwives should recognise their respective responsibilities in this area and take steps to minimise the risk of errors occurring and, when it does, minimise the damage that flows from it — the law would expect such a standard to be reasonable, having regard to the clear duty of care that is owed to the patient.

The Australian Commission on Safety and Quality in Health Care has identified medication safety as one of its priorities. Reducing error and harm from medicines through safe and quality use of medicines is identified as an important element of the work to achieve the objective of leading and coordinating national safety and quality improvements in healthcare.

The aim of the Medication Safety Program is to improve the safety of medication usage in Australia.[10] The environment in which medicines are regulated, prescribed, supplied, administered and monitored in Australia is complex but the Commission has chosen to focus its efforts in five areas:

1) standardising and improving systems (see medication charts and other standardisations, and tools for systems improvement);[11]
2) reducing practice gaps;[12]
3) employing continuity in managing medicines (see medication reconciliation);[13]
4) using technology (see Safety in E-health);[14]
5) advocating medication safety and quality by working with the National Medicines Policy Executive and other organisations.

One of the major changes has been the introduction of a National Inpatient Medication Chart. Since 2006 a number of charts have been developed for national usage, including charts for acute care, long stay in acute care and paediatric charts; the most recent project relates to charts for Residential Aged Care Facilities. Importantly there is also a list of national terminology, abbreviations and symbols.[15] All healthcare professionals need to be familiar with these standardised terms as their use will reduce the risk of error significantly.

Administrative considerations

Most hospitals and some other health organisations have a permanent drug committee made up of relevant personnel to formulate specific policy in relation to drug control and administration. Some hospitals and health centres are too small to warrant such a committee. Nevertheless, whatever situation prevails, hospital and health administrators should lay down firm and clear policies for employees concerning drug administration. The policies should:

1) Ensure that the relevant legislative provisions are implemented and adhered to.
2) Ensure that all staff concerned are advised of any relevant changes to the legislation which may occur from time to time. This can be easily achieved by bringing such changes to the attention of the staff through standard communication strategies.
3) Ensure that staff are informed and instructed about the use, requirements for handling, storage, contraindications and so on, of new drugs.
4) Ensure that policies exist for contentious issues that arise; for example:
   a) legibility of medication orders;
   b) procedures to be followed by staff in the making and taking of verbal medication orders, especially in an emergency.
5) Specify checking procedures for drugs of addiction and certain restricted substances, such as the frequency of checking by visually counting each substance, and which staff do the checking.
6) Identify procedures that should be followed if medication orders are to be transcribed.
7) Clarify what medications, if any, outside Schedule 4 and Schedule 8 substances, can be given by nursing and midwifery staff without a medical officer's authority or prescription; for example, such substances as paracetamol on the basis of what is commonly referred to as 'nurse- or midwife-initiated medications'.
8) Where appropriate, determine standard medication protocols, commonly referred to as Standing Orders, able to be followed by nursing and midwifery staff in emergency situations or in areas such as obstetric delivery wards, where many organisations have a standard medication protocol for routine admissions.

Clinical considerations

In the day-to-day task of administering medications, nurses and midwives should bear the following 12 considerations carefully in mind to help reduce the possibility of errors occurring.

1) The guiding principle behind the administration of medication is — if in any doubt, question and clarify with the prescribing practitioner concerned. A useful maxim is often described as 'The Five Rights' of medication safety: the *right* patient should receive the *right* dose of the *right* drug via the *right* route at the *right* time.
2) Read medication sheets carefully. If the handwriting is illegible, steps should be taken to have it clarified and, if need be, rewritten before the drug is administered. This very real problem can to some extent be overcome if the hospital administration rigidly adheres to the policy of legibility in the writing up of prescriptions and medication sheets. Also, if a nurse or midwife is present at the time the medication sheet is written up, they should ensure that the entry is legible and, if not, have it clarified immediately.
3) Check the labelling of the drug carefully. If it is an ampoule or tablet in a blister pack, check the labelling on the ampoule or blister, not the box or container it is in.

4) Leave medications in the packaging they arrive in from the pharmacy — don't transfer them to another container. Most of the Regulations make provision for such a situation.
5) Do not transcribe a patient's medication orders from his or her medication sheet into any other part of the patient's notes or other documents unless absolutely unavoidable. This eliminates the risk of transcription errors and the possibility that some other person may give a drug to a patient based on the transcribed error. Transcribing medication orders is not against the law as such, but it has become such an important issue for healthcare staff because of the great danger of errors arising in such a practice. Therefore it is essential that, in whatever system is devised in relation to medication, the necessity to transcribe such orders is eliminated or reduced to an absolute minimum.
6) If it is necessary, in an emergency situation, to take a drug order over the telephone, the following six steps should be observed:
   a) Obtain the patient's notes if possible.
   b) Ask the prescribing practitioner to repeat the order at least once — more if it is unclear.
   c) Repeat the order back to the prescribing practitioner.
   d) If a second nurse or midwife is present and available, have them listen to the order as a second check.
   e) Make an immediate entry in the patient's notes (not on a scrap of paper) recording the date, time, drug, amount, number of dosages and so on, and sign the entry. Have the second nurse or midwife, if available, countersign the entry. A problem that sometimes arises here is where to make the entry in the patient's notes; that is, in the medication sheet or in the body of the patient's notes. Unless contraindicated by hospital policy, there is no legal reason why the entry cannot be made on the medication sheet. It would certainly seem the most sensible thing to do, particularly as the prescribing practitioner has to countersign and confirm the order generally within 24 to 48 hours. Some hospitals take the view that the patient's medication sheet constitutes a hospital prescription form and as nurses and midwives in general (unless endorsed to prescribe as nurse practitioners or eligible midwives) cannot prescribe drugs they cannot write on the medication sheet. Whichever view is taken, it is more important to make the entry directly into the patient's notes and that the hospital administration make a clear policy on such a matter, which it then communicates to the staff concerned.
   f) Appropriate steps should be taken to ensure that the prescriber confirms the verbal order in writing in the patient's notes within a specified time. In most states and territories the Regulations specify the time, which usually ranges from 24 to 48 hours.
7) Registered nurses and midwives are presumed to have specific knowledge and expertise in relation to drugs, which they acquire as part of their training and education. That knowledge and expertise should cause them to question

medication orders carefully in certain situations rather than blindly follow instructions; for example:

a) if a dosage seems excessive in all the circumstances;
b) if the drug seems inappropriate having regard to known contraindications, drug interactions, side effects or allergies;
c) if the drug is one they have not encountered before.

8) If, after carefully checking the drug and dosage with the patient's medical practitioner, the nurse or midwife is still concerned, he or she should be able to communicate that concern to a person in authority for further checking. That may not be possible in isolated situations, but in most hospitals a system to deal with such concerns should be devised.
9) Whatever procedure for further checking does or does not exist, any query raised by a nurse or midwife with the prescribing practitioner concerning the suitability or dosage of a particular drug ordered for a patient should be documented immediately by the nurse or midwife in the patient's record. In making such an entry, care should be taken that it is factual and objective. For example, assume that the prescribing practitioner has prescribed an intravenous dose of 0.5 mg of digoxin for a patient. The registered nurse on duty feels that such a dose administered intravenously is excessive in the circumstances and wishes to check it with the prescribing doctor. In doing so, it is suggested that the following entry may appear in the patient's notes:

> 15.5.10: 14.00 Contacted Dr Brown concerning his order of 0.5 mg of digoxin IV. Dr Brown directed that the order be amended to 0.05 mg of digoxin IV. Medication sheet amended accordingly. P Smith RN.

OR

> 15.5.10: 14.00 Contacted Dr Brown concerning his order of 0.5 mg of digoxin IV. Dr Brown confirmed order. P Smith RN.

If the second example is the outcome and the nurse is still concerned, contact should be made with a person in authority, if such a system has been devised. If it has, the following entries may then appear:

> 15.5.10: 14.15 Contacted Dr Jones concerning Dr Brown's order of 0.5 mg of digoxin IV.
>
> 14.30 Received a telephone order from Dr Jones to change the order to read 0.05 mg of digoxin IV. Medication sheet amended accordingly. P Smith RN.

In the event that Dr Jones confirms Dr Brown's order, the following entry may appear instead of the last entry above:

> 14.30 Dr Jones telephoned and stated that he had discussed the order of 0.5 mg of digoxin IV with Dr Brown and he confirmed Dr Brown's order. P Smith RN.

10) Registered nurses and midwives should not be required to administer complicated drug regimes in specialised or high-dependency areas, unless they are assessed as competent to do so. This is particularly so with children where drug dosages are required to be fractionally precise and the margin for error is extremely small.
11) Where certain drugs are required to be checked prior to administration, they should be checked by two people. In situations where nurses or midwives work alone or in isolation this is often not possible. This problem frequently occurs with community nurses and midwives who are required to administer medications in the home. The drawing up of insulin for diabetic patients is a good example. In such situations the nurse or midwife concerned has no alternative but to administer the drug after carefully checking it alone. However, the patient is often highly knowledgeable about their own illness and regime, and if they are able to check and assist, it is always useful and instructive to involve them.
12) There are also instances where a community nurse is required to visit a patient in the home on a weekly basis. At that visit the nurse leaves prescribed medications in a 'dosette' box for the patient to self-administer at set times during the week. When that situation arises, the nurse should take all reasonable steps to ensure the medications are correctly administered — such as careful explanations and, if need be, written instructions to the patient and/or relatives as to the time and method such medications are to be taken, as well as any other relevant instructions. Where there is a language barrier between the nurse and patient, it may be necessary to arrange for an interpreter to be present. If that is not possible, perhaps the nurse can arrange to have the instructions translated in writing for the patient.

Endorsements for medication administration under the new national registration scheme

Under the new national registration scheme, there is provision under section 94(1) of the *Health Practitioner Regulation National Law Act 2009* (Qld) for a National Board (in this case the NMBA), to endorse the registration of a registered healthcare practitioner (in this case either a nurse or midwife) as being qualified to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of scheduled medicines if the registered nurse or midwife:

a) holds either of the following qualifications relevant to the endorsement —
   i) an approved qualification;
   ii) another qualification that, in the Board's opinion, is substantially equivalent to, or based on similar competencies to, an approved qualification; and
b) complies with any approved registration standard relevant to the endorsement.[16]

These endorsements will be discussed in detail in Chapter 8, but suffice it to say here that nurse practitioners are specifically endorsed under section 95; remote and

isolated practice registered nurses in Queensland have limited endorsement under section 94(1) (although this limited and specific endorsement will be reviewed to be more representative of the work of registered nurses at the earliest opportunity); and eligible midwives (once they are notated as such under s 38(2)) will also be endorsed for their scope of practice under section 94(1).

Criminal and professional issues relating to the administration of drugs

It is not unknown for a nurse or midwife to have a personal drug addiction problem. Nurses and midwives are often able to maintain such a habit because of their relatively easy access to drugs generally and, as registered nurses and midwives, to drugs of addiction in particular. The provisions of the various Poisons Acts and Regulations authorise registered nurses and midwives to be 'in possession of and supply certain drugs of addiction'. Such authority arises when they become registered and is generally symbolised by the possession of keys to the cupboard where the drugs are kept.

If this authority to possess and supply drugs is breached by self-administration, or by supplying or administering to another person other than a patient, the authority can clearly be withdrawn. Apart from anything else, such an action also constitutes a criminal offence under the provisions of the poisons or crimes legislation of each state and territory.

Should a registered nurse or midwife be found guilty (convicted) of such an offence, he or she will invariably be required to appear before the relevant panel or responsible tribunal described in Part 8 of the *Health Practitioner Regulation National Law Act 2009* (Qld) in the appropriate state or territory. The powers under the *Health Practitioner Regulation National Law Act 2009* (Qld) include the power to remove a nurse's name from the register, subject to certain provisions, thereby effectively depriving the nurse from pursuing employment in his or her profession or placing conditions on the nurse's right to practise. It is not uncommon for registered nurses to have their registration cancelled or suspended for varying periods of time as a result of convictions arising from drug offences related to their employment.[17]

CONCLUSION

The rules governing medication administration and management are changing rapidly at present, particularly with the changes to national registration and the advent of electronic prescribing. Nurses and midwives need to follow local policy and national developments closely.

Endnotes

Note: All links given below were last accessed on 20 January 2012.

1) Organisation for Economic Cooperation and Development Health Data: Statistics and Indicators for 30 countries, OECD, 2011, http://www.oecd.org/document/16/0,3746,en_2649_37407_2085200_1_1_1_37407,00.html.

2) Easton K, Morgan T and Williamson M, *Medication Safety in the Community: A Review*

of the Literature, National Prescribing Service, Sydney, 2009.

3) Roughhead L and Semple S, *Literature Review: Medication Safety in Acute Care in Australia*, University of South Australia, Adelaide, 2008.
4) See Appendix A below.
5) *Enrolled nurses and medicine administration: Explanatory notes and FAQs*, fact sheet, NMBA website, http://www.nursingmidwiferyboard.gov.au/FAQ-and-Fact-Sheets.aspx.
6) Poisons Standard 2011 (please note that amendments are made to the Standard throughout the year, therefore the website needs checking regularly for currency if you require accurate information about a schedule), http://www.comlaw.gov.au/Details/F2011L01612.
7) Commonwealth Department of Health and Ageing, *Guiding principles for medication management in the community: Guiding Principle 10: Nurse-initiated non-prescription medications*, 2006, http://www.health.gov.au/internet/main/publishing.nsf/Content/nmp-guide-medmgt-jul06-contents~nmp-guide-medmgt-jul06-guidepr10.
8) See, for example, Northern Territory Government, *Remote Health Atlas,* section on pharmacy: Chapter 16, 2012, http://www.health.nt.gov.au/Remote_Health_Atlas/Contents/Pharmacy/index.aspx.
9) South Australia Department of Health, *Code of Practice for the Storage and Transport of Drugs of Dependence*, 2000, http://www.dassa.sa.gov.au/webdata/resources/files/CS_ActCode_DOD_storage_trans.pdf.
10) Australian Commission on Safety and Quality in Health Care (ACSQHC), *Medication Safety*, 2010, http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-06.
11) ACSQHC, *National Inpatient Medication Chart*, 2009, http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/NIMC_001; and ACSQHC, *Tools for Systems Improvement*, 2008, http://www.health.gov.au/internet/safety/publishing.nsf/Content/NIMC_008_Tools.
12) ACSQHC, *Reducing Gaps in Practice*, 2010, http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/reducing-gaps-in-practice.
13) ACSQHC, *Assuring Medication Accuracy at Transitions of Care: Medication Reconciliation*, 2012, http://www.health.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-06_MedRecon.
14) ACSQHC, *Guide to Safe Electronic Medication Management (EMM) in Hospitals*, 2012, http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-08_ePrescribing2.
15) ACSQHC, *National Terminology, Abbreviations and Symbols to be Used in the Prescribing and Administering of Medicines in Australian Hospitals*, 2010, http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/NIMC_001_NTAS.
16) *Health Practitioner Regulation National Law Act 2009* (Qld), section 94(1), http://www.ahpra.gov.au/Legislation-and-Publications/Legislation.aspx.
17) Although the legislation on which this textbook is based has now been superseded, the *Professional Conduct Casebook* (2010) commissioned by the (then) NSW Nurses and Midwives Board, and co-authored by Adrian A and Chiarella M, provides a range of case law relating to drug misuse that is still relevant for nurses today. Order forms can be downloaded from http://www.nmb.nsw.gov.au/professional-conduct-books/default.aspx.

Appendix A: List of statutes and regulations governing medications in Australia

Narcotic Drugs Act 1967 (Cth)
Therapeutic Goods Act 1989 (Cth)
Therapeutic Goods Amendment Act (No 1) 2006 (Cth)
Therapeutic Goods (Charges) Act 1989 (Cth)

Therapeutic Goods Regulations 1990 (Cth)
Dangerous Substances Act 2004 (ACT)
Drugs of Dependence Act 1989 (ACT)
Medicines, Poisons and Therapeutic Goods Act 2008 (ACT)
Medicines, Poisons and Therapeutic Goods Regulation 2008 (ACT)
Drug and Alcohol Treatment Act 2007 (NSW)
Drug Court Act 1998 (NSW)
Drug Misuse and Trafficking Act 1985 (NSW)
Poisons and Therapeutic Goods Act 1966 (NSW)
*Poisons and Therapeutic Goods Regulation 2008 (*NSW)
Misuse of Drugs Act 1990 (NT)
Misuse of Drugs Regulations 1990 (NT)
Poisons and Dangerous Drugs Act 1983 (NT)
Poisons and Dangerous Drugs Regulations 2004 (NT)
Therapeutic Goods and Cosmetics Act 1986 (NT)
Drug Court Act 2000 (Qld)
Drug Court Regulation 2006 (Qld)
Drugs Misuse Act 1986 (Qld)
Drugs Misuse Regulation 1987 (Qld)
Health Act 1937 (Qld)
Health (Drugs and Poisons) Regulation 1996 (Qld)
Health Regulation 1996 (Qld)
Controlled Substances Act 1984 (SA)
Controlled Substances (Poisons) Regulations 2011 (SA)
Dangerous Substances Regulations 2002 (SA)
Health Care Act 2008 (SA)
Misuse of Drugs Act 2001 (Tas)
Poisons Act 1971 (Tas)
Poisons (Declared Restricted Substances) Order 1990 (Tas)
Poisons (Declared Restricted Substances) Order 1998 (Tas)
Poisons (Declared Restricted Substances) Order (No 2) 1998 (Tas)
Poisons (Drugs Of Dependence) Order 2009 (Tas)
Poisons (Exempted Public Institutions) Order 2006 (Tas)
Poisons (Exempted Public Institutions) Order 2010 (Tas)
Poisons List Order 2001 (Tas)
Poisons (Midwifery Substances) Order 2011 (Tas)
Poisons (Notifiable Restricted Substances) Order 2009 (Tas)
Poisons (Prescribed Periods) Order 2009 (Tas)
Poisons (Prohibited Substances) Amendment Order 2005 (Tas)
Poisons (Public Institutions) Order 2000 (Tas)
Poisons Regulations 2008 (Tas)
Poisons (Specified Substances) Order 2009 (Tas)

Therapeutic Goods Act 2001 (Tas)
Drugs, Poisons and Controlled Substances Act 1981 (Vic)
Drugs, Poisons and Controlled Substances (Commonwealth Standard) Regulations 2001 (Vic)
Drugs, Poisons and Controlled Substances Regulations 2006 (Vic)
Therapeutic Goods (Victoria) Act 2010 (Vic)
Drugs of Addiction Notification Regulations 1980 (WA)
Poisons Act 1964 (WA)
Poisons Regulations 1965 (WA)

Chapter 7

Report writing

Confidentiality of and access to patient records (including e-records, incident reporting and open disclosure)

Report writing

The writing of patient reports is an integral part of a nurse's work. The patient's records, particularly the written reports by healthcare personnel that are incorporated into the record, should constitute an ongoing account of the patient's healthcare experience. The written reports should provide an assessment of the patient's progress for the healthcare professionals concerned and, on the patient's transition to their next stage of treatment, provide a record of treatment given, progress made and a history for future consultation as required. In addition, a patient's healthcare history and the accompanying records are used for teaching, quality and research purposes. From time to time, a patient's healthcare records will be required as evidence in court, although it is important to stress that this is not the most important reason for writing good healthcare records. However, when that situation arises, the relevant health authority or the individual medical practitioner is served with a subpoena requiring them to produce the relevant records. A patient's records can be used in civil and criminal proceedings and in coronial hearings.

In civil proceedings against healthcare organisations or providers, a patient's record is often used as evidence to support an allegation that a certain treatment was wrongly given or that there was a failure to give a particular treatment. The patient's record can also be used as supporting evidence of other matters that may be in dispute in civil proceedings; for example, that a particular injury occurred as a result of an accident and the circumstances in which it was alleged by the patient to have occurred.

In criminal proceedings, a patient's record can be used as evidence that an assault and/or injury actually happened and to show the nature and extent of the injury. For example, in relation to a charge of sexual assault, it may be that the first place the victim presented for help was the emergency department of a hospital. On arrival the victim would invariably give an account of events leading up to his or her presence at the hospital. In such a situation, the healthcare professional's record of the words used in relation to the complaint made and the injuries sustained may become important evidence in the criminal charge that may well follow.

In coronial hearings, the purpose of the inquiry is to determine the nature and cause of death where the legislation requires that a coronial hearing is conducted to make such a determination (see Chapter 9). Here the records may be used to track a person's deterioration, to identify whether any errors or adverse events occurred during the patient's stay, or to ascertain the condition of the person when they were first (and possibly subsequently) seen by the healthcare professional.

For whatever purpose a patient's records may be required in legal proceedings, such records, including the nursing records, will be subject to close and careful scrutiny. It is important, therefore, that these records meet the standard expected of them, having regard to the purpose for which patients' records are used. If the records are an accurate and factual account of good patient care, they will provide valuable assistance in a court of law.

Relevant considerations in writing reports

There is currently no specified format or outline for proper report writing. There are a number of different techniques or models of documentation which include: progress notes; various types of charting by exception, such as documentation of variance, and charting of clinical incidents; problem-oriented medical records; and more standardised formats, such as clinical or critical pathways, clinical algorithms and pre-designed clinical care plans, which are becoming more prevalent with computerised records. Although many organisations still use handwritten records, computerised systems are also reasonably commonplace in our healthcare system, with some organisations using a combination of both. Electronic health records, or e-records as they are known, are explored in more detail later in this chapter.

Certain points are common to all forms of records and should always be borne in mind. These can best be summarised as follows:

- No entry concerning the patient's treatment should be made in a patient's record on behalf of another nurse. Examples of this have unfortunately arisen, particularly in relation to fluid balance charts.
- Reports should be accurate, brief and complete. Accuracy is obviously essential and it is important to distinguish between what is personally observed and what is related as part of a patient's complaint of illness or injury; for example, the difference in the record between writing 'patient assaulted by two men' and 'patient reported that he had been assaulted by two men'. Unless the assault was actually witnessed, the patient's complaint of injury is clearly hearsay evidence and must be reported as such. 'Brief and complete' may sound like a contradiction in terms, but primarily it is important to avoid unnecessary verbosity. As part of ensuring the reports are complete, reference should always be made where a patient refuses any treatment or medication or acts in a manner contrary to healthcare advice. For example, it is a patient's right to refuse their medication, as was discussed in Chapter 4, but it is important to document the refusal so that any adverse outcomes can be monitored and accounted for should they occur. If there is no record of such a refusal occurring, the record is obviously incomplete.

- If reports are still being handwritten, they should be legible. Incorrect interpretation of a person's handwriting can lead to mistakes and has done so in the past. Remember, if unsure about what is written, always check. This problem will hopefully be overcome with the introduction of computerised records, although typographical errors can still occur and any concerns or uncertainties still need to be raised with the person who has entered the data.
- Remember that some computer programs have predictive text and also auto-correct, which can create problems if the language is technical and not easily recognised by the computer program.
- Reports should be objectively written. This critical distinction can best be summarised as follows: 'Learn to record what you see, not what you think you see'. Three examples follow.

  A simple rule to follow is only to write an objective, definite statement of fact. That is, record what you heard, saw or did and provide as much specific clinical information as possible, such as measurements of clinical signs and results.

  1) A statement such as the 'patient appears to be drunk' would be more accurately reported in the following, or similar, terms:
     - the patient is unsteady on his or her feet;
     - the patient's speech is slurred;
     - the patient's breath smells strongly of alcohol.
  2) A statement such as the 'patient appears to be shocked' would be more accurately reported in the following, or similar, terms:
     - the patient is pale and sweating;
     - the patient's pulse rate and blood pressure are specified;
     - the patient has peripheral cyanosis, or the patient's fingers and toes are blue.
  3) A statement such as the 'patient appears to be sleeping' can be contentious. How to report the patient's sleep status, especially in night duty reports, is one area in which nurses commonly seek guidance. The justification for the use of the word 'appears' in this context has been that some qualification and/or caveat is required in cases where the nurse has written 'patient slept well' but the next morning the patient reports that he or she didn't sleep well at all. This can be difficult for nurses as, even if the patient had one unobserved period of wakefulness but was sleeping on all occasions when the nurse checked on them, for the patient that interruption to their sleep, coupled with the strange bed and strange sounds of the hospital ward, may well feel like a very poor night's sleep indeed.

  For patients who require constant attention throughout the night, the question of sleep becomes almost a side issue. However, it is hoped that a patient will sleep for as much of the night as is possible, but it is still good nursing practice to observe patients at regular intervals. Here the most accurate and definite report

that the nurse can give is to report on the patient's sleep status as at the time of observation; for example: 'Patient observed at regular intervals (if possible mention the time). When so observed, patient was sleeping'. Obviously where the patient does not sleep it should also be appropriately and accurately reported.

In conclusion on this point, the use of the word 'appears' as a means of qualification is not appropriate.

- Entries in reports should be made at the time a relevant incident occurs. This is known as 'contemporaneous reporting'. Nurses have traditionally written their reports at the completion of each shift. There is no legal reason for this and it would be more appropriate to make a relevant entry as soon as possible after an incident or episode of care occurs. Not only will the nurse have better recall of the event, in some cases if the nurse waits until the completion of the shift to record an occurrence, that episode may have been overtaken by subsequent events — particularly if a patient's condition worsens and various treatments are commenced and tests undertaken. Trying to recreate the accurate sequential order at that stage can prove confusing. Any entry that is made should be prefaced by the date and time and followed by the nurse's signature.
- Abbreviations should not be used in reports unless they are accepted healthcare organisation abbreviations. The diversity of healthcare organisations in which nurses and other healthcare personnel train and later work leads to a similar diversity of abbreviations used — often with confusing and misleading results. Every healthcare facility, as a matter of administrative policy, should have a list of accepted abbreviations accompanied by the accepted interpretation of each abbreviation. No other abbreviations should be used in the patient's records. It is also critical that those abbreviations are accepted by all healthcare professionals, as different professional groups can use the same acronyms or abbreviations to describe different phenomena related to their own area of practice.
- If medical terminology is used in reports, the nurse must be sure of the exact meaning, otherwise it could prove misleading.
- Any errors made while writing an entry in a patient's record should be dealt with by drawing a line through the incorrect entry and initialling it before continuing. Total obliteration of the incorrect entry may suggest that there is something to hide. Writing over mistakes with emphasis and inserting words left out between lines can also cause confusion and misunderstanding, and should definitely be avoided. Liquid correcting fluid should never be used to correct mistakes.
- A number of factors are worth remembering that may reduce the risk of an incorrect entry being made:
  - Do not make an entry in a patient's record before checking the name on the record.
  - Do not make an entry in a patient's record that refers to an identifying room or bed number only. Patients are known to have been moved while

staff are absent (for example, during a meal break), and remembering a patient simply as 'the patient in room 12' can sometimes cause incorrect entries to be made in the chart at the end of room 12 (apart from any other considerations).

– Make sure that the patient's name and identifying number is on every sheet of the patient's record before making an entry on that sheet. Some observation sheets are single sheets which are not immediately incorporated into the body of the patient's record. If these single sheets are not identified before any entry is made, there is the risk that the wrong patient's observations may be recorded on the sheet unwittingly, or the sheet may be wrongly identified after an entry is made and then filed in the wrong patient's record.
– Avoid wherever possible making notes concerning a patient on loose paper for rewriting into the patient's notes. Not only is it common for such scraps of paper to be lost, but every time an entry is transcribed in this fashion there exists a margin for error in the transcription itself and there is the risk that the entry will be made in the wrong patient's notes. It is also duplication of work and therefore wastes time.

Integrated recordkeeping

Integrated report writing in the patient's record is essential. In the past, nurses and medical officers traditionally wrote separate reports about a patient and these reports were separately filed. On many occasions neither party read the reports of the other. That such a situation ever arose is odd enough — that it might continue would be clearly unsatisfactory and contrary to good practice.

To obtain a comprehensive picture of the patient's condition and progress, it is essential that the reports of all healthcare personnel concerned in caring for the patient be part of an ongoing integrated holistic record. It is also much safer, as it requires all personnel involved in caring for the patient to read the reports of other colleagues. Not only is such an undertaking instructive and illuminating for everybody, but it must also help to ensure that all personnel are aware of what is happening to the patient — clearly the most important consideration of all. Most hospitals have already introduced such an integrated system.

Reading the patients' records

Nurses must ensure that they read their patients' records thoroughly and regularly. Many hospitals and some health centres rely on a system of verbal reporting at the commencement of each shift as the major way of passing on the history and any relevant information concerning the patient that has arisen during the previous shift. If the nurse is unfamiliar with the patient, the nurse should read the written record to gain a more extensive overview of the patient.

Clearly the verbal handover is generally an efficient way of quickly reporting on all patients to all relevant staff on a shift-by-shift basis. However, the verbal report must be seen as an adjunct to the written report and not a substitute

for it. Important information and pathology results that may not have been mentioned in the verbal report may not be known and noted, sometimes until it is too late.

The value of good nursing records when used as evidence in court

Sometimes the quality of the nursing record has been high and this has been advantageous for nurses in terms of both their verbal evidence[1] and their written evidence.[2] In the case of *Spasovic v Sydney Adventist Hospital*[3] the patient claimed that the nurses employed at the hospital and the doctors who cared for him failed to exercise reasonable care in assessing and treating complaints he made and symptoms he exhibited, in particular a headache, which were caused by a small cerebral haemorrhage from an arterio-venous malformation (AVM) in his brain. He claimed that, because of their failure to assess and treat him, he was discharged from hospital without the small cerebral haemorrhage or the AVM having been diagnosed, and later on the same day he suffered a major cerebral haemorrhage from the AVM, which caused him to have very serious permanent disabilities.

The healthcare records were a central plank of the evidence offered in defence by the hospital and the medical staff. The lawyers representing the hospital made the following representation as reported by the judge, James J:

> It was submitted by counsel … that I should accept the Hospital's medical records and particularly the Hospital notes (that is the Integrated Progress Notes), as reliable evidence and indeed the most reliable evidence concerning the plaintiff's headache and events happening during the plaintiff's stay in the Hospital.
>
> As was submitted by counsel for the first defendant, the Hospital's medical records and particularly the Hospital notes have the virtues, as evidence, of being contemporaneous records; of having been made by or under the supervision of trained observers; of having been made, not for the purposes of litigation or out of self-interest or with hindsight, but for the purpose of disinterestedly recording, progressively, what was happening during the plaintiff's stay in the Hospital; and of being, on the face of them, quite detailed and not merely perfunctory.
>
> The virtue of having been made without hindsight, that is of having been made without knowledge of the plaintiff's major haemorrhage on 20 January 1996 and its consequences, is a virtue possessed by the entries in the Hospital notes and by very little other evidence, lay or expert, in the case. I have also had the benefit of seeing and hearing many of the nurses who made notes give evidence and I formed a generally favourable impression of them.[4]

The judge concluded that he had decided, in general, to accept the records as being 'an accurate record of the matters purportedly recorded in them'.[5] This case provides a striking example of how good records, made with the sole purpose of providing good nursing care, not only furnished evidence as to the existence of good

nursing care but also enabled the judge to find both the written and verbal evidence provided by the nurses to be reliable.

The difficulties for nurses when records produced in court are poor

Unfortunately, on numerous occasions the poor quality of nursing records has meant that the courts have (understandably) taken them literally and found their depiction of nursing care wanting. Perhaps because nursing has such a strong oral tradition, the nursing records have never been the major focus of authenticity for nurses.[6] Greater reliance has traditionally been vested in the oral nursing handover.[7] Thus, questions such as 'at what time did you take Mr Smith's 6 o'clock observations?', however illogical they may sound to listeners, are a consequence of the fact that four-hourly observation charts are often pre-printed with the times, 2, 6, 10, 2, 6, 10.[8] This type of chart should no longer be used as it results in a number of anomalies. For example, if a nurse has a caseload of eight patients, only one can have their observations recorded exactly on the hour. In addition, the records often take the form of graphs or plans, meaning times are abbreviated or rounded off to save space. However, if an observation is taken and found to be abnormal, and particularly if a patient is seriously ill or a patient's condition is deteriorating, the exact time of the observation must be written.

This does not excuse poor recording practices, but it goes some way to explaining them. Clearly this is problematic for nurses who would wish their records to be accorded professional authority. Especially when witnesses have poor recollection of events, judges rely on written evidence, meaning that nurses who do not produce accurate records will find it difficult to have their account of a particular incident treated as legitimate if it is inconsistent with the written evidence. When nurses' charts and times have been tendered in courts and tribunals, and have been found to be inaccurate, the nurse witness's credibility has suffered as a consequence. For example, a finding that 'these times were all approximate times, were not accurate times and cannot be relied upon' led to the judge declaring that 'I accept [the anaesthetist's conflicting] evidence in view of the inexactitude of the nurses' times as shown by the contradictions on the charts'.[9] The occurrence of inaccuracy in nurses' records elicits considerable irritation in judgments.[10] Although medical practitioners' records have also been the objects of judicial criticism, there is a stronger written culture in medicine and thus perhaps a tendency to greater accuracy.[11] This has often enabled their records, and thus their evidence, to carry more weight than those of nurses'. This reinforces the significance patient records can have in legal proceedings. It also underscores the importance nursing staff should place on recording their entries in an accurate, objective and timely manner, taking into account the whole of the patient's condition.

Principles in relation to documentation

Many employers, key organisations, government and others have issued guidelines and principles for documentation. These are designed to provide sound advice to healthcare professionals and it is important that all healthcare professionals are aware of the relevant guidelines and principles for their organisation. At the time of

writing, public health services nationally have been restructured into Local Health/Hospital Networks (LHNs) and it remains to be seen whether guidelines will be issued locally or at jurisdictional level, although it is likely that they will continue to be issued at state or territory (jurisdictional) level.

One example of such a guideline is the New South Wales Health Department document *Principles for Creation, Management, Storage and Disposal of Health Care Records*.[12] These principles were reviewed and updated in 2008 and still provide sound advice in relation to all aspects of health record management. They are set out in Box 7.1.

BOX 7.1
NSW HEALTH POLICY DIRECTIVE, PRINCIPLES FOR CREATION, MANAGEMENT AND DISPOSAL OF HEALTH CARE RECORDS, PD2005_127

Individual record

A separately identifiable individual health care record is created at the time of a person's first attendance at a health service. Every attendance or service provided must be recorded in the health care record. All entries in the health care record are integrated in chronological sequence, and in the case of electronic records, are accessible and linked to the individual main record. (This includes both inpatient and ambulatory care services.)

Continuity of care

Health care records are used to promote a continuity of a person's care across service boundaries, subject to the principle of confidentiality.

Confidentiality

All information in a person's health care record is confidential. Disclosure of this information is only permissible under certain specific conditions.

Authenticity

All entries in a person's health care record are accurate statements of fact or statements of clinical judgement relating to care, observation, assessment, diagnosis, management/treatment, and professional advice.

Relevance

All records of an episode of a person's care are relevant to that individual and do not contain prejudicial, derogatory or irrelevant statements about the person.

Completeness and comprehensiveness

A person's health care record provides complete and comprehensive documentation of all aspects of care in a chronological manner.

Responsibility for documentation

Health Care personnel who provide a person with care, assessment, diagnosis, management and/or professional advice are responsible for legibly documenting and

dating this activity in the person's health care record. (Note: all computerised and hand written systems shall have the capacity to enable identification of individual health personnel. In a computerised system, this will require the use of an appropriate identification system eg computer signatures.)

Timeliness of documentation

Documentation in the health care record is to occur at the time of, or as soon as practicable following the provision of care, observation, assessment, diagnosis, management/treatment, professional advice, or any other matter worthy of note.

Ownership

The health care record is the property of the health service providing care and not individual practitioners.

Access

As a general rule health care records are only available to: the person to whom the record relates; those health care personnel currently involved in the continuing care, observation, assessment, diagnosis, management/treatment and professional advice; and in other limited circumstances as in accordance with legislation, common law and departmental policy.

Quality improvement, review, evaluation and research

Health care records are evaluated using a multidisciplinary approach on an ongoing basis to assess the quality of documentation, management, storage and to enable continuous quality improvement and research in health care. Health care records are also subject to audit.

Durability

Documents that relate to episodes of a person's care are maintained as a permanent record for the duration of the retention period. Entries will not fade, be erased or deleted over time. In addition, records stored electronically shall be capable of being reproduced on paper and adequate backups kept.

Storage and security

Health care records must be stored in a secure place which can only be accessed by authorised personnel.

Retention

Records are held for the period required by law and policy, and are accessible when necessary.

Disposal

Health care records are disposed of in such a manner that will preserve the confidentiality of any information they contain relating to any person.

At an international level, in 2007, the South East Asian Region of the World Health Organisation (SEARO WHO) issued the *Guidelines for Medical Record and Clinical Documentation*;[13] these are particularly concise as they are based on three guiding principles, set out below.

Guiding Principle 1: Comprehensive and complete record

Clinical staff have a professional obligation to maintain documentation that is clear, concise and comprehensive, as an accurate and true record of care.

Guiding Principle 2: Patient-centred and collaborative

Documentation focuses on patients, is collaborative, and is appropriate to the setting in which the care is provided and the purpose for which the information is recorded.

Guiding Principle 3: Confidential

Documentation systems (including electronic systems) will ensure and maintain patient confidentiality, in all care settings.[14]

One of the most useful aspects of the SEARO WHO guidelines is the criteria they identify for the auditing and monitoring processes. They suggest that the standard and quality of the documentation should assess compliance with:

- relevant documentation policy and procedures;
- professional/industry/sector standards;
- relevant legislation;
- consistency of understanding/documentation practices across the organisation;
- identified gaps of inconsistencies/discrepancies in documentation;
- content/context of documentation; and
- requirements for coding.[15]

In addition, the guidelines suggest that the criteria against which the evidentiary compliance should be reviewed are as follows:

- that the documentation is contemporary;
- that the documentation is a factual and true record (authentic);
- that the documentation is based on evidence and observation (accurate);
- that the entries made are timely;
- that the documentation is inclusive of planned care provided and actions taken; and
- that the documentation is a complete record.[16]

These are useful criteria against which to review both the policies for documentation and the documentation itself, as it is important that both guidelines and documentation are reviewed and updated on a regular basis.

Advice available to nurses on documentation and confidentiality

In addition to advice on what and how to document, there is also valuable advice available from most health departments and some employers on the relationship between documentation and confidentiality. One of the most comprehensive small

brochures on this topic, *A guide to maintaining confidentiality in the public health system*,[17] is available on the South Australian Department of Health's website. It provides specific advice about both handwritten and e-records, and due to its size, can be easily downloaded and kept in a notebook or on a smartphone for easy access.

In addition to its specific advice, it concludes with the following set of 'important points to remember', which are valid for all nurses and midwives, regardless of their place or location of employment:

- You are only permitted to use or divulge client information on a **need to know basis** in the course of performing your work, unless you have prior written authority from the health service executive (or delegate) to divulge the information in other circumstances, or you are required by law to report certain information; for example, notification of child abuse and notifiable diseases to the appropriate authorities.
- **Accessing** your own medical records in hardcopy or electronic format is a breach of confidentiality.
- The client's **medical record** is a confidential document, the content of which should only be divulged in the course of your working duties unless prior authorisation from the health service executive (or delegate) has been obtained, or you are required by law to report certain information.
- You must only use the **health service electronic systems** to perform your work. Electronic systems must not be used to gain access to client information for personal use.
- **Conversations** about clients must not be conducted in the presence of, or be overheard by, those not entitled to know the information in the performance of their daily duties.
- Disclosure of client information **over the phone** should be limited and undertaken in accordance with health service policy. It is **your individual responsibility** to maintain confidentiality when you have access to, or knowledge of, confidential information.[18]

Documentation in nursing homes

A relatively small proportion of our elderly population in Australia lives in nursing homes. Those who do so live there because they are no longer able to care for themselves or be cared for in the community and will require long-term nursing care with progressive deterioration over time as they age. Thus, they are especially vulnerable and it is now recognised that they require specialised nursing care. Over the years, the need to protect both the environment in which these frail elderly people live and the standard of care they receive has been recognised and enshrined in legislation, both at state and federal level. The major piece of legislation is the *Aged Care Act 1997* (Cth) that sets out (*inter alia*) a number of principles relating to the environment, care and management of elderly people.[19] Nurses often seek guidance about documenting the care of people living in nursing homes, given that they are there for a long time, and questions such as how often to document and what to document are commonly raised. In 2011, the Aged Care Funding

Instrument[20] was reviewed and a number of recommendations were made in relation to documentation. These are available on the Australian Government Department of Health and Ageing website.

Specifically, the website offers the NATFRAME, a format designed 'to help staff communicate and deliver high-quality care for older people'.[21] It provides for the initial assessment of those entering care and for the continuing evaluation, reassessment and planning of care. The framework is divided into three sections:

1) initial assessment, comprising admission data and assessment;
2) assessment tools, of which there are a number, including depression assessment tools, mini mental state examination tools and falls risk assessment tools;
3) ongoing care, comprising care profile, management charts and progress notes.

One of the reasons for the introduction of a (relatively) new Aged Care Funding Instrument (ACFI) was to 'reduce the documentation burden on staff'.[22] Whilst this tool is used as a means of accessing funding for aged care service providers, it is clear that the assessment of residents who require the funding will fall to the nursing staff on most occasions. The ACFI consists of 12 care need questions. Diagnostic information about mental and behavioural disorders and other medical conditions is also collected. This information is used to categorise residents as having low, medium or high care needs in each of the following care domains:

- activities of daily living (ADLs);
- behaviour;
- complex healthcare.[23]

The assessment pack is extremely detailed and various charts need to be kept for a number of days to have a full assessment of residents' care needs.[24] Nurses who are going to work in the aged care sector will need to be familiar with these assessment and documentary requirements and will need to keep abreast of updates on the Department of Health and Ageing website. Aged care provider organisations also offer valuable updates and advice in relation to documentation requirements in aged care.[25]

The national e-health transition authority (NEHTA)

At the time of writing, it seems impossible to consider report writing and record-keeping without first outlining the plans of the current government for a national e-health system. The National E-Health Transition Authority Limited (NEHTA) was established by agreement of the national, state and territory governments in 2005 to develop better ways of collecting and securely exchanging health information electronically.[26] The NEHTA website states that the organisation is committed to:

- Improving the quality of healthcare services, by enabling authorised clinicians to access a patient's integrated healthcare information and history, directly sourced from clinical notes, test results and prescriptions using standardised clinical data formats and terminologies.

- Streamlining multi-disciplinary care management, enabling seamless handovers of care by ensuring efficient electronic referrals; authorised access to up-to-date clinical opinions and patient healthcare histories via shared patient health records; and fast, secure mechanisms for directly exchanging important notifications between healthcare providers.
- Improving clinical and administrative efficiency, by standardising certain types of healthcare information to be recorded in e-health systems; uniquely identifying patients, healthcare providers and medical products; and reforming the purchasing process for medical products.
- Maintaining high standards of patient privacy and information security.[27]

In the past 12 months, significant progress has been made towards the scheme becoming a reality. Despite some controversy, the *Healthcare Identifiers Act 2010* (Cth) was passed in June 2010 which creates the potential for every person in Australia to have an individual healthcare identifier (IHI), which will be managed through Medicare. This is a fundamental building block of a national e-health scheme and enables the work of NEHTA to progress in a more coordinated fashion. NEHTA plans to seek to drive the adoption of a range of new healthcare capabilities across the sector, which will incorporate both foundations and solutions.

The foundations include: Individual Healthcare Identifiers (IHI), Healthcare Provider Identifiers for Individuals (HPI-I), Healthcare Provider Identifiers for Organisations (HPI-O), Authentication, Secure Messaging, Clinical Terminologies and Supply Chain; and the E-Health solutions feature: Pathology, Diagnostic Imaging, Medication Management, Referral and Discharge Summary.[28]

There are now plans in place for individuals to hold Personally Controlled Electronic Health Records (PCEHR) — a secure, electronic record of a person's medical history, stored and shared in a network of connected systems. The PCEHR will bring key health information from a number of different systems together and present it in a single view. It is anticipated that e-discharge summaries, e-medication, e-pathology and e-referrals will be part of this process.[29] As part of the 2010/11 federal budget, the Commonwealth Government announced a $466.7 million investment over 2 years for a national PCEHR system for all Australians who choose to register online, from 2012–13.

From July 2012, all Australians who choose to can register for a PCEHR. As the PCEHR system matures, Australians who use a PCEHR will be able to see their important health information in one consolidated view. They will be able to share this information with trusted healthcare practitioners, who in turn will be able to access their patient's PCEHR to support the delivery of high-quality healthcare regardless of where and when it is needed. A Concept of Operations document has now been developed for public release.[30]

Clearly such a wide-ranging proposal will address some of the difficulties encountered with handwritten records. In addition, many computerised systems for prescribing already have built-in systems for detecting errors, which have been demonstrated to reduce prescribing adverse events.[31] However, if the patient care is not good, the record can only reflect the care delivered and in this way, the record

is only ever a reflection of the actual patient care. Having said that, the record may well provide standardised formulae for documentation of care that may enable more consistent information to be documented and shared. The majority of the considerations below will nonetheless continue to be relevant for all records, both handwritten and computerised.

The American Health Information Management Association (AHIMA) has developed a set of guidelines to assist nurses and midwives in maintaining authentic e-health records.[32] They identify four areas of concern in relation to e-health fraud, as follows:

1) **Authorship integrity:** borrowing record entries from another source or author and representing or displaying past as current documentation and (in some instances) misrepresenting or inflating the nature and intensity of services provided.
2) **Auditing integrity:** inadequate auditing functions that make it impossible to detect when an entry was modified or borrowed from another source and misrepresented as an original entry by an authorised user.
3) **Documentation integrity:** automated insertion of clinical data and visit documentation using templates or similar tools with predetermined documentation components with uncontrolled and uncertain clinical relevance.
4) **Patient identification and demographic accuracy:** automated demographic or registration entries generating erroneous patient identification, leading to patient safety and quality of care issues as well as enabling fraudulent activity involving patient identity theft or providing unjustified care for profit.[33]

The publication also provides a set of solutions to ensure accuracy and, whilst these are prepared for the American e-health system, they are equally as relevant to the Australian setting.[34]

Given the concerns about internet and computer security that exist in the general population, questions of privacy and confidentiality are specifically relevant to health record administrators, consumers and clinicians. On 1 November 2010 the Australian Government's Office of the Privacy Commissioner was integrated into the Office of the Australian Information Commissioner (OAIC).[35] The privacy site contains a great number of links that relate to some of the privacy issues and concerns about the introduction of electronic health records. Privacy and confidentiality is discussed in more detail below.

Reporting and documenting adverse events and clinical incidents

Following work undertaken in South Australia in anaesthetic incident reporting in the late 1980s, in 1993 the Australian Government provided funding to the Australian Patient Safety Foundation (APSF) to continue that work and to set up pilot studies in other specialty areas. In 1994, the brief was broadened to develop an incident monitoring model that could be used on an institutional basis, rather than being specialty-focused. A pilot study was conducted in six tertiary facilities in different Australian states.

The national release of results from the Quality in Australian Health Care Study (QAHCS) in 1995[36] prompted strong reactions from government, healthcare professionals and the general public. The South Australia Government took the initiative to look at options for reducing risk in South Australian healthcare units. As a consequence, in November 1996, the APSF was engaged to develop and implement a patient incident reporting and monitoring system for all public health units in that state — the Australian Incident Monitoring System (AIMS).[37] In 2004, the (then) Australian Council for Safety and Quality in Health Care (now the Australian Commission on Safety and Quality in Health Care) developed and recommended to Health Ministers a national specification for incident reporting and management systems to support the reporting and management of incidents at the local level and to identify better ways to manage hazards and risks to improve systems of care.[38] The incident reporting systems are developed in each jurisdiction and are set out by name and resource access in Table 7.1.

An example of a new incident management system is the Victorian Health Incident Management System Project (VHIMS). The information on the website cautions that a standardised, state-wide incident reporting data set and data collection mechanism will in itself not provide many benefits unless the data collected is meaningful and appropriate mechanisms are established to use this data to drive ongoing quality improvement initiatives.[39] The potential benefits of the new system being rolled out in Victoria are as follows:

- better understanding of type, frequency and severity of incidents that are occurring within Victorian health services, via an ability to pool data across the state;

Table 7.1
Incident reporting systems

State/territory	Name of program	Website
ACT	Riskman	http://www.health.act.gov.au/c/health?a=dlpubpoldoc&document=2202
NSW	NSW Patient Safety Program	http://www.cec.health.nsw.gov.au/programs/patient-safety.html
NT	Riskman	No external website available. Nursing staff log on through intranet
Qld	Health Incident Management System	http://www.health.qld.gov.au/qhpolicy/docs/pol/qh-pol-012.pdf
SA	Incident Management System	http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/safety+and+quality/incident+management/incident+management+system
Tas	Electronic Incident Monitoring System (EIMS)	No external website available. Nursing staff log on through intranet
Vic	Clinical Risk Management Program	http://www.health.vic.gov.au/clinrisk/ http://www.health.vic.gov.au/clinrisk/vhims/index.htm
WA	Advanced Incident Monitoring System	http://www.safetyandquality.health.wa.gov.au/home/

- the ability for health services to compare their incident information across like organisations;
- the ability to use this information to measure the effectiveness of various quality improvement projects that aim to reduce the prevalence of particular incidents;
- the ability to use this information to provide justification for new quality improvement initiatives, targeted toward identified problematic areas;
- a reduction in the rate of clinical incidents, through appropriately targeted quality improvement initiatives; and
- opportunities to allocate resources normally consumed by incidents toward other areas of patient care where resources are required.[40]

The VHIMS website provides the definitions of 'incident' and 'clinical incident' set out in Box 7.2. The website also has an easily accessible online e-learning package for staff.[41]

When incidents are reported, they are coded by severity and likelihood of recurrence under the Severity Assessment Code (SAC), and rated numerically from 1, being the most severe, to 4. New South Wales Health requires that SAC1 events must be notified to the Department of Health, and a root cause analysis (RCA) completed.[42] An RCA is an indepth investigation as to the cause and circumstances that created the environment in which the event occurred. This process is protected by what is known as qualified privilege,[43] which is granted to certain committees in New South Wales under the *Health Administration Act 1982*, Division 6B. The Western Australia Office of Safety and Quality in Healthcare explains that the 'qualified privilege scheme is designed to encourage hospitals and health professionals to conduct quality improvement activities and investigate the causes and

BOX 7.2
VICTORIAN HEALTH INCIDENT MANAGEMENT SYSTEM DEFINITIONS[44]

Incident: An event or circumstance which could have resulted, or did result, in unintended or unnecessary harm to a person and/or a complaint, loss or damage (ACSQHC 2006).

Clinical incident: An event or circumstance which could have resulted, or did result, in unintended or unnecessary harm to a person receiving care (minor variation on ACSQHC 2006 definition).

A clinical incident can be an **adverse event**: An incident in which harm resulted to a person receiving healthcare (ACSQHC 2006). A clinical incident can also be a **near miss**: An incident that did not cause harm (ACSQHC 2006). Near misses encompass incidents that had potential to cause harm but didn't, due to timely intervention and/or luck/chance.

contributing factors of clinical incidents by protecting certain information from disclosure and protecting clinicians involved in the activity from civil liability'.[45] It goes on to explain that it is important to review what went wrong to improve the safety and quality of healthcare, and to find ways to prevent the event from happening again. It is generally believed that people will be more likely to talk about the mistakes they made if they know that the information they disclose cannot legally be revealed to anyone. Disclosure of healthcare mistakes allows the identification of environments conducive to errors, and this facilitates the redesign of systems to create an environment in which it is more difficult to make a mistake.[46] In New South Wales this right for information obtained during the course of the investigation to be kept confidential has recently been confirmed by the Administrative Decisions Tribunal.[47]

Nurses are the largest group of healthcare workers, so it is hardly surprising that they are also the largest group of reporters of clinical incidents and near misses.[48] Nurses all need to become fully conversant with the incident-reporting policy in their workplace. As with all other documentation, it is most important that the reports submitted are factual and accurate. This can present a challenge at times, as a sentinel or adverse event is most distressing for all concerned, and there can be a tendency for incident reports to be written in emotional language. However, it is most important for the safety and quality process that the reports can be carefully analysed to understand exactly what went wrong so that measures can be put in place to minimise the risk of such an event reoccurring. If nurses are distressed following an adverse event, it is important that they seek support from their more experienced colleagues. If they do not feel comfortable discussing the matter with their immediate colleagues, all healthcare organisations are required to provide support through some form of employee assistance scheme. The occupational health and safety officers can provide advice on how to access this support.

Confidentiality of healthcare records

The requirement for nurses to observe a duty of confidentiality is spelled out in the Nursing and Midwifery Board of Australia (NMBA) *Code of Conduct* and *Code of Ethics*.[49] It is self-evident that, if nurses are to expect their patients to proffer highly sensitive information so they can care for them appropriately, patients must feel secure that the nurses will not divulge that information without their consent. Clearly if the patient does consent to the sharing of confidential information, the duty is overridden, but only to the extent that the patient has consented. For example, if the person is happy for the nurse to share information with the team but not the family, there is still a duty to maintain confidentiality as specified.

There are a number of exceptions to this rule in each state and territory. The first is where it is mandated or permitted by statute or court order to share the information. An example of the former is mandatory reporting of notifiable diseases and suspected child abuse. An example of the latter is a subpoena requiring the production of data gathered in research. A judge could, however, exercise judicial discretion in deciding whether it should be admitted in evidence. However, the information can often be excluded as it is not the best evidence of the facts in issue.

The second major exception is where it is 'in the public interest'. This rather vague common-law principle is based on the broad and ancient notion that the duty of confidence owed to an individual gives way to the obligation to report which 'lies on every member of the society to discover every design which may be formed contrary to the laws of society, to destroy the public welfare'.[50] This obligation tends to fall into two areas; first, that which is sometimes described as the 'iniquity rule', that is, the disclosure of a crime or misdeed; and second, the 'balancing rule' where the disclosure must be balanced in the public interest against the need for confidentiality. Disclosure of criminal activity or other civil wrong, even if it involves disclosing information that is confidential, may sometimes be justified on this ground. As Kirby P (as he then was) said about the balancing act in the *Spycatcher case*: 'public interest in an open discussion of the matters raised in *Spycatcher* [relating to the affairs of ASIO and ASIS] outweigh the residual equitable duty of confidence or fiduciary duty of silence operating on [the author's] conscience'.[51]

However, that disclosure must be in the public interest. If the public interest is not advanced by the disclosure, it will not be permissible to breach confidentiality.

Regulations currently exist to allow a chief health officer to release epidemiological data and a director-general to release other information for research purposes. Such data are only released to bona fide researchers and on condition that the confidentiality of data is maintained.[52] Overall, the expectation is that we will take great care to respect the confidences entrusted to us by our patients. Each state and territory has legislation which requires people who deal with healthcare records to maintain confidentiality.

In addition, healthcare workers and public health organisations can owe a common-law duty of confidentiality to their clients/patients. This duty arises from the nature of the relationship between health workers and their clients/patients.

Healthcare providers may be sued in the civil courts by clients/patients for breaches of confidentiality. Damages may be awarded for any injury or harm to a client/patient caused by the breach of confidentiality. Health workers should be aware, however, that a common-law action for breach of confidence would also recognise a defence that the disclosure was lawful where a statutory obligation or power exists to justify disclosure. Where a confidentiality obligation exists a client/patient may also, if aware that the duty may be breached, seek court orders to prevent the breach occurring.

The increasing complexity of our society has resulted in the perceived need for a variety of government and private sector agencies to acquire and store information of a personal and often sensitive nature about individuals, which seriously threatens the notion of individual privacy in the conduct of people's daily lives. The need to compile a healthcare record about a patient or client is obvious and the use to which such records are formally put has already been stated and cannot be seriously questioned. The very nature of healthcare records is such that highly personal and sensitive material is often contained in them. It is therefore important that hospitals and health centres recognise and respect the right of individual privacy as far as their patients or clients are concerned and that steps be taken to respect that privacy, particularly in relation to healthcare records.

The use, storage of and access to a patient's or client's healthcare record should be (and in most cases is) the subject of clear guidelines by every hospital and health organisation. Guidelines do not have the legal and binding force of legislation, but should be recognised for what they are meant to be — a clear statement of policy directives in relation to a particular issue of general importance in an organisation, and which quite often embody legal principles and/or requirements.

As previously discussed, electronic information, mail and communication systems are increasingly used as effective means of maintaining and transferring documentation and information in the healthcare environment. Precautions must be taken to ensure that clinical staff are fully informed of appropriate, safe and secure use of electronic information systems. It should be assumed that any and all clinical documentation will be scrutinised at some point.

Patients' right of access to their healthcare records

AT COMMON LAW

In contrast with health departments' guidelines, which support the patient's right to have access to his or her medical records, the High Court of Australia decision in *Breen v Williams* in 1995 discounted such a proposition as a legal right both at common law and as a fiduciary duty owed by the medical practitioner to his or her patient.[53] Ms Breen had commenced action in the Supreme Court of New South Wales seeking an order that her plastic surgeon give her access to her medical records. She had spent 5 years attempting to obtain her medical records to support her participation in a class action in the United States over breast implants. Ms Breen claimed she had a proprietary right and interest in the information contained in her medical records, or was otherwise entitled to the information, and sought orders giving her access to her medical records to examine them and to obtain copies. The doctor argued that because his medical notes were:

> … prepared by me in the belief that they will remain private to me, they often contain conclusions, commentary and musing which might well be different in form and substance if the notes were prepared by me in the knowledge that the patient was entitled to a copy of my records.[54]

The initial judge hearing the matter refused Ms Breen's application on the grounds that:

> The defendant was not made the plaintiff's medical adviser for the purpose of making him a collector or repository of information for the plaintiff to have available to her for whatever purposes she chooses. Collecting and retaining information was … a subsidiary purpose, to lead only to medical advice and treatment to be administered by him or on his referral.[55]

Ms Breen appealed to the New South Wales Court of Appeal who dismissed her appeal by a majority.[56] She then appealed to the High Court where her appeal was also dismissed. Justice Brennan gave the following reasons for doing so:

> For these reasons, I would hold that information with respect to a patient's history, condition or treatment obtained by a doctor in the course or for the purpose of giving advice or treatment to the patient must be disclosed by

> the doctor to the patient or the patient's nominee on request when (1) refusal to make the disclosure requested might prejudice the general health of the patient, (2) the request for disclosure is reasonable having regard to all the circumstances and (3) reasonable reward for the service of disclosure is tendered or assured. A similar duty may be imposed on the doctor by the law of torts but in particular situations, for example, some emergency treatments, the relationship between doctor and patient may not give rise to a duty that extends so far. It is not necessary now to consider that problem.
>
> An undertaking to provide information is one thing; a duty to give the patient access to and to permit the patient to copy the doctor's records is another. The doctor's duty to provide information not only can be discharged, but also in some circumstances ought to be discharged, without allowing the patient to see the doctor's records. Where that duty can be performed without giving the patient access to the doctor's records, there is no foundation for implying any obligation to give that access. There is no evidence in this case to suggest that access to the respondent's records might have been necessary to avoid or diminish the possibility of prejudice to the appellant's health.[57]

LEGISLATIVE PROVISIONS IN RELATION TO RIGHT OF ACCESS TO HEALTHCARE RECORDS AND PRIVACY CONSIDERATIONS

In response to the High Court decision in *Breen v Williams* the Australian Government set out requirements known as the Information Privacy Principles for federal agencies in relation to personal information, in the *Privacy Act 1988* (Cth). The provisions initially established an Office of the Privacy Commissioner (OPC) but this role and title has just changed to that of the Office of the Australian Information Commissioner (OAIC). However, the OPC issued guidelines and principles in relation to the protection of privacy and these at the time of writing are unchanged.

The Information Privacy Principles under the *Privacy Act 1988* (Cth) address the following issues:

Principle 1 — Manner and purpose of collection of personal information
Principle 2 — Solicitation of personal information from individual concerned
Principle 3 — Solicitation of personal information generally
Principle 4 — Storage and security of personal information
Principle 5 — Information relating to records kept by record-keeper
Principle 6 — Access to records containing personal information
Principle 7 — Alteration of records containing personal information
Principle 8 — Record-keeper to check accuracy etc of personal information before use
Principle 9 — Personal information to be used only for relevant purposes
Principle 10 — Limits on use of personal information
Principle 11 — Limits on disclosure of personal information.[58]

In terms of access to healthcare records, Principle 6 states that:

> Where a record-keeper has possession or control of a record that contains personal information, the individual concerned shall be entitled to have access to that record, except to the extent that the record-keeper is required or authorised to refuse to provide the individual with access to that record under the applicable provisions of any law of the Commonwealth that provides for access by persons to documents.[59]

These requirements were extended to the private sector in the *Privacy Amendment (Private Sector) Act 2000* (Cth). The private sector provisions cover all healthcare service providers in Australia regardless of size. A second set of principles, known as the National Privacy Principles, were developed to set minimum standards for privacy in the private sector. The National Privacy Principles provide requirements relating to the questions of collection, use and disclosure, data quality and security, openness, access and correction, anonymity, identifiers, trans-border flows and sensitive information.[60] Further, specific information relating to healthcare records in the private sector is also available.[61]

The federal *Privacy Act* does not regulate state or territory agencies except for the Australian Capital Territory. All states and territories have developed privacy requirements, either enshrined in different pieces of legislation or as guidelines or codes. The various state and territory provisions are available from the website of the Office of the Australian Information Commissioner.[62]

OPEN DISCLOSURE

A related matter that sits between the recording of adverse events and a patient's right of access to information, if not necessarily to his or her healthcare record, is the movement to inform patients and their families when a person has suffered an adverse event. This process is referred to as 'open disclosure' (OD) and was introduced into Australian mainstream healthcare requirements by the (then) Australian Council for Safety and Quality in Health Care (now the Australian Commission on Safety and Quality in Health Care) when it published the National Open Disclosure Standard.[63] This was endorsed by all Health Ministers in July 2003. In the past, often due to legal concerns, healthcare professionals were defensive about admitting that something had gone wrong, even when no fault was necessarily attached to it, usually because of the perceived threat of legal action.

However, it is now considered to be best practice to explain to people what has happened when things go wrong, and it is not considered that this is necessarily an admission of liability (see Chapter 3). The standard defines four elements to the process of OD, which is a means of encouraging open communication when things go wrong in healthcare. The elements include an expression of regret; a factual explanation of what happened; the consequences of the event; and the steps being taken to manage the event and prevent a recurrence.[64] The National Standard contains a set of eight principles, many of which are equally relevant to recordkeeping.

1) **Openness and timeliness of communication.** When things go wrong, the patient and their support person should be provided with information about what happened in an open and honest manner at all times. The open disclosure process is fluid and may involve the provision of ongoing information.
2) **Acknowledgment.** All adverse events should be acknowledged to the patient and their support person as soon as practicable. Healthcare organisations should acknowledge when an adverse event has occurred and initiate the open disclosure process.
3) **Expression of regret.** As early as possible, the patient and their support person should receive an expression of regret for any harm that resulted from an adverse event.
4) **Recognition of the reasonable expectations of patients and their support person.** The patient and their support person may reasonably expect to be fully informed of the facts surrounding an adverse event and its consequences, to be treated with empathy, respect and consideration, and to be provided with support in a manner appropriate to their needs.
5) **Staff support.** Healthcare organisations should create an environment in which all staff are able and encouraged to recognise and report adverse events and are supported through the open disclosure process.
6) **Integrated risk management and systems improvement.** Investigation of adverse events and outcomes are to be conducted through processes that focus on the management of risk. Outcomes of investigations are to focus on improving systems of care and will be reviewed for their effectiveness.
7) **Good governance.** Open disclosure requires the creation of clinical risk and quality improvement processes through governance frameworks where adverse events are investigated and analysed to find out what can be done to prevent their recurrence. It involves a system of accountability through the organisation's chief executive officer or governing body to ensure that these changes are implemented and their effectiveness reviewed.
8) **Confidentiality.** Policies and procedures are to be developed by healthcare organisations with full consideration of the patient's, carer's and staff's privacy and confidentiality, in compliance with relevant law, including Commonwealth and state and territory privacy and health records legislation.[65]

Open disclosure is now well established, particularly in the Australian public hospital system, and seems to open the potential for improved relationships between healthcare practitioners and patients.[66] Whilst it does not relate directly to documentation and medical records, it is nevertheless closely related to the patients' rights to information, an issue that is also discussed in Chapter 4.

CONCLUSION

It is clear that healthcare records play a most important role in the lives and practice of nurses. Their good management and meticulous upkeep will protect not only the care and safety of the patient, but also the professional standing of the individual nurse. It is most important that nurses keep up-to-date with the laws and policies

relating to documentation and privacy, particularly as the use of electronic records becomes mainstream.

Endnotes

Note: All links given below were last accessed on 4 January 2012.

1) *Savoie v Bouchard* (1982) 23 CCLT 83; *Corley v North West Hertfordshire Health Authority HA* (1997) 8 *Med LR* 45.
2) *Briffet v Gander and District Hospital Board* (1992) 103 Nfld & PEIR & 326 APR 271.
3) *Spasovic v Sydney Adventist Hospital* [2003] NSWSC 791 (12 September 2003) per James J, http://www.austlii.edu.au/au/cases/nsw/supreme_ct/2003/791.html. See also *Durant v Tamworth Base Hospital* [2003] NSWSC 73, where it was found 'in relation to his relevant complaints of pain [the plaintiff's evidence is] in this regard to be totally outweighed in a probative sense by the notations in the hospital records' (at [31] per Newman AJ), http://www.austlii.edu.au/cgibin/sinodisp/au/cases/nsw/NSWSC/2003/73.html.
4) *Spasovic v Sydney Adventist Hospital* [2003] NSWSC 791 at [388]–[390].
5) Ibid, at [391].
6) Robinson Wolf Z, 'Nurses' stories: discovering essential nursing', *MedSurg Nursing*, FindArticles.com, 2008, http://findarticles.com/p/articles/mi_m0FSS/is_5_17/ai_n31340007/.
7) Parker J, Gardner G and Wiltshire J, 'Handover: The collective narrative of nursing practice', (1992) *Australian Journal of Advanced Nursing* 9(3): 31–37. See more recently McKnight M, 'A grounded theory model of on-duty critical care nurses' information behaviour: The patient-chart cycle of informative interactions', (2007) *Journal of Documentation* 63(1): 57–73, http://www.emeraldinsight.com/journals.htm?articleid=1589317&show=abstract.
8) Zeitz K and McCutcheon H, 'Observations and vital signs: ritual or vital for the monitoring of postoperative patients?' (2006) *Applied Nursing Research* 19(4): 204–211.
9) *Laidlaw v Lion's Gate Hospital* (1969) 70 WWR 727 at 739.
10) *Joseph Brant Memorial Hospital v Koziol* (1977) 77 DLR (3d) 161; Inquest touching the death of MWF, Adelaide and Claire Coroner's Courts, 22 June 1993, Thompson G, Mr; *Farrell v Cant* (1992) 104 Nfld & PER 9; Inquest touching the death of CWCK (T), Perth Coroner's Court, 30 March 1994, McCann D A, Mr; *Hill v West Lancashire HA* (1997) 8 *Med LR* 196.
11) *Breen v Williams* [1995] HCA 63; (1996) 186 CLR 71.
12) NSW Health, *Principles for Creation, Management, Storage and Disposal of Health Care Records*, Policy Directive PD2005_127, 2005, http://www.health.nsw.gov.au/policies/PD/2005/pdf/PD2005_127.pdf.
13) South East Asian Region of the World Health Organisation, *Guidelines for Medical Record and Clinical Documentation*, 2007, http://www.searo.who.int/LinkFiles/2007_Guidelines_for_Clinical_Doc.pdf.
14) Ibid, p 9.
15) Ibid, p 6.
16) Ibid.
17) South Australian Health Department, *A guide to maintaining confidentiality in the public health system*, 2007, http://www.publications.health.sa.gov.au/cgi/viewcontent.cgi?article=1002&context=patri.
18) Ibid, p 4.
19) Records Principles 1997, as amended 20 March 2008, made under subsection 96-1(1) of the *Aged Care Act 1997* (Cth), http://www.comlaw.gov.au/comlaw/Legislation/LegislativeInstrumentCompilation1.nsf/0/AC8C368FD64A823DCA25741-20012D9CA?OpenDocument.
20) Commonwealth Department of Health and Ageing, *Aged Care Funding Instrument Report*, Aged Care website, 2011, http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-acfi-review-may2011-toc~ageing-acfi-review-may2011-ch6.
21) Commonwealth Department of Health and Ageing, NATFRAME website, http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-natframe.htm~ageing-rescare-natframe01.htm.
22) Commonwealth Department of Health and Ageing, *New Funding Model for Residential Aged Care*, Welcome to the Aged Care Funding Instrument website, http://www.health.gov.au/acfi/.

23) Commonwealth Department of Health and Ageing, *New Funding Model for Residential Aged Care, Aged Care Funding Instrument factsheets*, http://www.health.gov.au/internet/main/publishing.nsf/content/ageing-acat-secure-acfi-acat-factsheet.htm.

24) Commonwealth Department of Health and Ageing, *New Funding Model for Residential Aged Care, Aged Care Funding Instrument Appraisal Pack*, http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acfi-using-conducting.htm.

25) See the following websites for examples: Aged Care Association of Australia, http://www.agedcareassociation.com.au/; Aged and Community Services Association, http://www.agedservices.asn.au/; and Aged Care Australia, a government site that provides advice and access to people needing to obtain care for the elderly, http://agedcare.gov.au.

26) National E-Health Transition Authority website, http://www.nehta.gov.au/.

27) Ibid, http://www.nehta.gov.au/about-us/strategy.

28) Ibid, http://www.nehta.gov.au/about-us/nehta-blueprint.

29) Ibid, http://www.nehta.gov.au/ehealth-implementation/pcehr-lead-sites.

30) Ibid, http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/pcehr-document.

31) Ammenwerth E, Schnell-Inderst P, Machan C and Siebert U, 'The effect of electronic prescribing on medication errors and adverse drug events: A systematic review', (2008) *J Am Med Inform Assoc* 15(5): 585–600.

32) AHIMA e-HIM™ Work Group: Guidelines for EHR Documentation Practice, 'Guidelines for EHR Documentation to Prevent Fraud', (2007) *Journal of AHIMA* 78, no. 1: 65–68, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_033097.hcsp?dDocName=bok1_033097.

33) Ibid.

34) Appendix C, *Solutions*, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_033095.hcsp?dDocName=bok1_033095.

35) An interim site for the Office of the Australian Information Commissioner is available at www.oaic.gov.au. The www.privacy.gov.au site will be maintained until a site incorporating all OAIC material is established.

36) Wilson R McL, Runciman W B, Gibberd R W et al., 'The quality in Australian health care study', (1995) *Med J Aust* 163: 458–471.

37) Australian Patient Safety Foundation website, History and objectives, http://www.apsf.net.au/index.php.

38) Australian Commissioner on Safety and Quality in Health Care, *Health Service Standards and Accreditation*, 2011, http://www.safetyandquality.gov.au/our-work/accreditation/.

39) *Victorian Health Incident Management System Project (VHIMS)*, http://www.health.vic.gov.au/clinrisk/vhims/index.htm.

40) http://www.health.vic.gov.au/clinrisk/vhims/objective.htm.

41) http://vhimsedu.health.vic.gov.au/.

42) http://www.health.nsw.gov.au/pubs/2005/sac_matrix.html.

43) NSW Health Policy Directive PD2007_061, *Incident management*, 2007, http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_061.pdf.

44) http://www.health.vic.gov.au/clinrisk/vhims/objective.htm.

45) Western Australian Department of Health, Office of Safety and Quality in Healthcare, *Qualified Privilege*, http://www.safetyandquality.health.wa.gov.au/clinical_incid_man/qualified_priv.cfm.

46) Ibid.

47) *Bray v North Coast Area Health Service* [2009] NSW ADT 93 (4 May 2009).

48) Nuckols T, Bell D and Liu H, 'Rates and types of events reported to established incident reporting systems in two U.S. hospitals', (2007) *Quality & Safety in Health Care* 16 at 164–8.

49) Nursing and Midwifery Board of Australia, http://www.nursingmidwiferyboard.gov.au/Codes-and-Guidelines.aspx.

50) *Annesley v Earl of Anglesea* (1743) 16 State Tr 1139.

51) *Attorney-General (UK) v Heinmann Publishers Australia Pty Ltd* (1987) 10 IPR 153 (NSW Court of Appeal).

52) http://www.nhmrc.gov.au/publications/hrecbook/03_law/04.htm.

53) *Breen v Williams* [1995] HCA 63; (1996) 186 CLR 71.

54) *Breen v Williams* (SC(Eq) (NSW), Bryson J, No. 2363/94, 10 October 1994, unreported).

55) Ibid.
56) *Breen v Williams* (1994) 35 NSWLR 522.
57) *Breen v Williams* [1995] HCA 63; (1996) 186 CLR 71.
58) Office of the Australian Information Commissioner (OAIC), *Information Privacy Principles under the Privacy Act 1988 (Cth)*, http://www.privacy.gov.au/materials/types/infosheets/view/6541.
59) Ibid.
60) OAIC, *National Privacy Principle*, http://www.privacy.gov.au/materials/types/infosheets/view/6583.
61) OAIC, *Health Information and the Privacy Act 1988 — A Short Guide for the Private Health Sector (January 2002)*, http://www.privacy.gov.au/materials/types/brochures/view/6522.
62) OAIC, *State and Territory Privacy Laws*, http://www.privacy.gov.au/law/states.
63) Australian Council for Safety and Quality in Health Care (ACSQHC), *National Open Disclosure Standard*, 2005, http://www.health.gov.au/internet/safety/publishing.nsf/Content/a-zpublicationsm-o/$File/OpenDisclosure_web.pdf.
64) ACSQHC, *National Open Disclosure Standard Factsheet*, 2005, http://www.health.gov.au/internet/safety/publishing.nsf/Content/C3D94BA657FEE027CA2573E00000B3FA/$File/opendisclfact.pdf at p 3.
65) ACSQHC, *National Open Disclosure Standard*, 2005, http://www.health.gov.au/internet/safety/publishing.nsf/Content/a-zpublicationsm-o/$File/OpenDisclosure_web.pdf at p 12.
66) Iedema R, Jorm C, Wakefield J, Ryan C and Dunn S, 'Practising open disclosure: clinical incident communication and systems improvement', (2009) *Sociology of Health & Illness* 31(2) at 262–77.

This page intentionally left blank

Chapter 8

Professional regulation of nurses and midwives

Introduction

This chapter will describe the new Australian national registration and accreditation scheme, a significant and ambitious national innovation that is the first of its kind in a federated system in the world. There is much interest internationally in its progress. Prior to 1 July 2010, each of the eight states and territories (also known as jurisdictions) had its own registration scheme for a number of designated professional groups, but certainly all jurisdictions had their own registration legislation for nursing and midwifery. Overall there were more than 85 healthcare professional boards and 66 Acts of Parliament to govern the implementation of the legislation in each of the jurisdictions. On 1 July 2010, the new National Registration and Accreditation Scheme came into being as a result of passing legislation in the Queensland Parliament. This legislation established 10 healthcare professional registration boards and one overarching management organisation to support the boards and employ the staff who work in the scheme. The Australian Health Practitioner Regulation Agency (AHPRA) is the organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia.[1]

Relevant legislation and structure of the scheme

AHPRA's operations are governed by the *Health Practitioner Regulation National Law Act 2009* (Qld) (hereafter, the *National Law*), as in force in each state and territory, which came into effect on 1 July 2010. Under this law, for the first time in Australia, 10 healthcare professions are regulated by nationally consistent legislation — this one Act of Parliament governs the full operation and implementation of the National Registration and Accreditation Scheme across the selected healthcare professions, including nursing and midwifery. The selected professions to date are chiropractors, dental care (including dentists, dental hygienists, dental prosthetists and dental therapists), medical practitioners, nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists. From 1 July 2012, four new professions will join the National Registration and Accreditation Scheme — Aboriginal and Torres Strait Islander health

practitioners, Chinese medicine practitioners, medical radiation practitioners and occupational therapists.

The object of the *National Law* is set out in Part 1, section 3(1) of the Schedule as follows:

> … to establish a national registration and accreditation scheme for —
>
> a) the regulation of health practitioners; and
> b) the registration of students undertaking —
>
> i) programs of study that provide a qualification for registration in a health profession; or
> ii) clinical training in a health profession.

The scheme also has a number of objectives, set out in section 3(2) as follows:

a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and
b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and
c) to facilitate the provision of high quality education and training of health practitioners; and
d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and
e) to facilitate access to services provided by health practitioners in accordance with the public interest; and
f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

The traditional purpose of a professional regulatory scheme is to protect the public — those presiding over disciplinary tribunals and committees for the purpose of professional regulation are said to exercise a 'protective jurisdiction'.[2] However, this scheme also has a number of other desirable objectives relating to workforce mobility and flexibility. The system now works in the same way as the Australian drivers' licensing system — a person registers in one state but their licence enables them to drive anywhere in Australia without having to apply for a new licence to drive in each state in which they wish to travel. Similarly now, although a person might register, say, with the Northern Territory State Board of the Nursing and Midwifery Board of Australia (NMBA), they will be able to practise nursing and/or midwifery in any jurisdiction in Australia. Thus, clearly the national scheme should facilitate workforce mobility. It is simply a new development to have this objective made explicit in a scheme that has traditionally been about protecting the public — a process which has on occasion been argued to limit access to certain professions and create monopolies.[3]

The National Registration and Accreditation Scheme is overseen by the Australian Health Workforce Ministerial Council (Ministerial Council), whose purpose is to direct the National Agency and National Board about policies to be applied.[4] Directions can include matters relevant to the policies, administrative processes, procedures or particular proposed accreditation standards or any amendments, but cannot be about a particular person, qualification, application, notification or proceeding. In addition, the Ministerial Council is required to approve registration standards recommended by the National Board established for the particular healthcare profession, but has the discretionary power to ask a National Board to review an approved or proposed registration standard. The Ministerial Council is comprised of each jurisdiction's Health Minister and the Federal Health Minister.[5]

The Ministerial Council is supported by the Australian Health Workforce Advisory Council (Advisory Council), whose role is to provide independent advice to the Ministerial Council about any matter relating to the National Scheme. However, the advice cannot be about a particular person, qualification, application, notification or proceeding. It comprises seven members appointed by the Ministerial Council — a Chairperson, plus three members with expertise in health and/or education.[6]

As previously stated, the scheme is administered by AHPRA, which is overseen by the Australian Health Practitioner Regulation Agency Management Committee. This committee comprises at least five members: the Chairperson, two people with expertise in health and/or education and training, and two with business or administrative expertise. None is able to be a current or former registered health practitioner.[7] The functions of AHPRA (*inter alia*) are set out in Box 8.1.

The structure of the new scheme is set out in Figure 8.1.

The National Boards

As of 1 July 2012, the four new boards mentioned above became operational. There are 14 National Boards. As seen in Figure 8.1, AHPRA's national office provides support to the National Boards and the state, territory and regional offices provide support to the corresponding local boards of the National Boards. The National Board for nursing and midwifery is the Nursing and Midwifery Board of Australia (NMBA). Because of the sheer numbers of nurses and midwives in Australia, the NMBA has a committee of the National Board in each jurisdiction. These committees are somewhat confusingly also called boards, but rather than have the powers of NMBA, they are there to administer the *National Law* by delegation from NMBA.[8] In particular for nursing and midwifery, the state and territory boards make registration and notification decisions about individual nurses and midwives. The only exception is in New South Wales, where, under a co-regulatory model, complaints (or notifications as they are called under the *National Law*), are managed by a separate organisation known as the Health Professionals Council Authority (HPCA). Complaints about nurses and midwives in New South Wales are reviewed and determined by the Nursing and Midwifery Council of New South Wales, and the HPCA, an administrative body of the Health Administration Corporation, provides the administrative and secretarial support to each of the 10 New South Wales councils in their primary role to protect the public. The councils themselves

BOX 8.1
FUNCTIONS OF THE AUSTRALIAN HEALTH PRACTITIONER REGULATION AGENCY (AHPRA)[9]

- Provide administrative assistance and support to the National Boards and board committees in exercising their functions
- In consultation with the National Board, develop and administer procedures, to ensure the efficient and effective operation of the National Boards
- Establish procedures for the development of accreditation standards, registration standards and codes and guidelines approved by the National Boards, to ensure the national registration and accreditation scheme operates in accordance with good regulatory practice
- Negotiate in good faith with, and attempt to come to an agreement with, each National Board on the terms of a health profession agreement
- Establish and administer an efficient procedure for receiving and dealing with applications for registration as a healthcare practitioner, and other matters relating to the registration of registered healthcare practitioners
- In conjunction with National Boards, keep current and publicly accessible national registers of registered healthcare professionals for each healthcare profession
- Keep a current and publicly accessible list of approved programs of study for each healthcare profession
- Establish an efficient procedure for receiving and dealing with notifications/complaints against persons who are or were registered healthcare practitioners and persons who are students, including by establishing a national process for receiving notifications/complaints about registered healthcare practitioners in all professions
- Provide advice to the Ministerial Council in connection with the administration of the national registration and accreditation scheme
- If asked by the Ministerial Council, give the Council assistance or information reasonably required by the Council in connection with the administration of the national registration and accreditation scheme
- Perform any other function given to the Agency by or under the *National Law*.

receive and process any complaints about registered healthcare professionals.[10] HPCA staff are employed by the Director-General of NSW Health, to whom the Director of the HPCA reports.[11] The *National Law* governs the powers of the National Boards. Their functions are set out in Box 8.2.

Principles of the new National Registration and Accreditation Scheme

The new National Scheme has three guiding principles:

1) to operate in a transparent, accountable, efficient, effective and fair way;[12]
2) to set reasonable registration fees (having regard to the efficient and effective operation of the scheme);[13] and

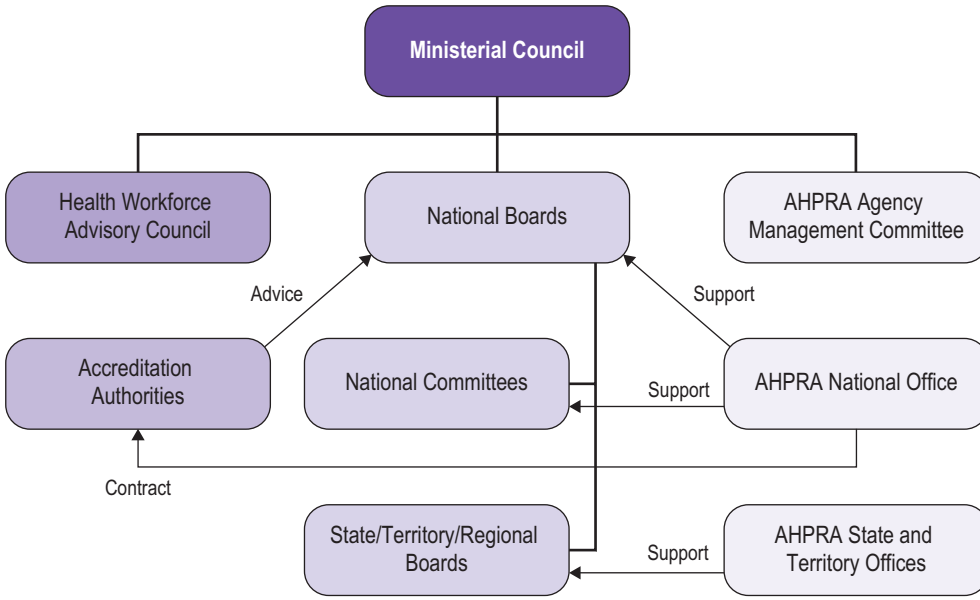


Figure 8.1 Structure of the new scheme

BOX 8.2
FUNCTIONS OF THE NATIONAL BOARDS[14]

a) to register suitably qualified and competent persons in the health profession and, if necessary, to impose conditions on the registration of persons in the profession;

b) to decide the requirements for registration or endorsement of registration in the health profession, including the arrangements for supervised practice in the profession;

c) to develop or approve standards, codes and guidelines for the health profession, including —

   i) the approval of accreditation standards developed and submitted to it by an accreditation authority; and

   ii) the development of registration standards for approval by the Ministerial Council; and

   iii) the development and approval of codes and guidelines that provide guidance to health practitioners registered in the profession;

d) to approve accredited programs of study as providing qualifications for registration or endorsement in the health profession;

e) to oversee the assessment of the knowledge and clinical skills of overseas trained applicants for registration in the health profession whose qualifications are not approved qualifications for the profession, and to determine the suitability of the applicants for registration in Australia;

f) to negotiate in good faith with, and attempt to come to an agreement with, the National Agency on the terms of a health profession agreement;

g) to oversee the receipt, assessment and investigation of notifications about persons who —

   i) are or were registered as health practitioners in the health profession under this Law or a corresponding prior Act; or

   ii) are students in the health profession;

h) to establish panels to conduct hearings about —

   i) health and performance and professional standards matters in relation to persons who are or were registered in the health profession under this Law or a corresponding prior Act; and

   ii) health matters in relation to students registered by the Board;

i) to refer matters about health practitioners who are or were registered under this Law or a corresponding prior Act to responsible tribunals for participating jurisdictions;

j) to oversee the management of health practitioners and students registered in the health profession, including monitoring conditions, undertaking and suspensions imposed on the registration of the practitioners or students;

k) to make recommendations to the Ministerial Council about the operation of specialist recognition in the health profession and the approval of specialties for the profession;

l) in conjunction with the National Agency, to keep up-to-date and publicly accessible national registers of registered health practitioners for the health profession;

m) in conjunction with the National Agency, to keep an up-to-date national register of students for the health profession;

n) at the Board's discretion, to provide financial or other support for health programs for registered health practitioners and students;

o) to give advice to the Ministerial Council on issues relating to the national registration and accreditation scheme for the health profession;

p) if asked by the Ministerial Council, to give to the Ministerial Council the assistance or information reasonably required by the Ministerial Council in connection with the national registration and accreditation scheme;

q) to do anything else necessary or convenient for the effective and efficient operation of the national registration and accreditation scheme;

r) any other function given to the Board by or under this Law.

3) to impose restrictions on practice only if necessary to ensure health services are provided safely and of appropriate quality.[15]

The scheme is intended to provide uniformity by assuring consistent national standards for registration and professional conduct; efficiency with the intended reduction of 'red tape' and more streamlined and effective processing; and increased collaboration through more sharing, learning and understanding between professions. However, the concept of consistency is not intended to mean that 'one size fits all'. Despite a number of uniform requirements across the professions such as mandatory professional indemnity insurance, mandatory continuing professional development, a minimum English Language Standard, mandatory criminal record and identity checks and mandatory notifications,[16] there is still a degree of difference in the way the professions impose their requirements.

The national registers

Under the new scheme there are now national online registers. These can be accessed easily by the public to check a practitioner's registration status, simply by entering their name into a search engine and viewing the results.[17] The search will confirm that the person is registered — the word 'registered' is in the column 'registration status', indicating they are legally able to practise — and identify whether there are any 'endorsements', 'conditions', 'notations', 'reprimands' or 'undertakings' on their registration. This does not apply to practitioners on the non-practising register, or those whose registration is suspended, or those with a condition which stops them from practising. However, health matters will not be recorded there. The five terms above are derived from the *National Law* and are explained in a glossary on the AHPRA website. The terms are defined for the purposes of this chapter in Table 8.1.

For the first time ever, there are two separate registers for nursing and midwifery. This means that a person can be registered as a nurse and not a midwife and vice versa, although it is obviously quite possible to be registered as both. In addition, a person can opt to be practising or non-practising for the first time nationally. This means that people who wish to retain the title of registered nurse or midwife will be able to do so for a nominal fee even when they are not intending to practise.[18] However, if they wish to return to the practising register they would need to meet the requirements for re-entry to practise, which means that (*inter alia*) they must be able to demonstrate recency of practice.[19] In addition to being registered as a registered nurse, it is also possible to be registered as an enrolled nurse (either solely or concurrently) and endorsed as a nurse practitioner (which would primarily require registration as a registered nurse). In addition to being registered as a midwife, it is also possible to be endorsed as a midwife practitioner and notated and endorsed as an eligible midwife. Both these qualifications require the applicant primarily to be registered as a midwife. The concept of the midwife practitioner is a carry-over from some but not all of the old state-based schemes and is not the preferred title of the Australian College of Midwives (ACM) for advanced midwifery practice in Australia.[20] Instead the ACM have worked with the Commonwealth Government and other stakeholders to develop the title and role of the eligible

midwife. This is discussed later in this chapter in a section exclusively focusing on the regulation of midwives.

Table 8.1
Definition of key terms that may appear on the public register in relation to a practitioner's registration

Key term	Definition from AHPRA Glossary
Endorsement	An endorsement of registration recognises that a person has additional qualifications or expertise in particular areas. There are a number of different types of endorsement available under the *National Law*: • endorsement for scheduled medicines • endorsement as a nurse practitioner • endorsement as a midwife practitioner • endorsement for acupuncture • endorsement for the approved area of practice.
Condition	A condition may be imposed by the National Board or an adjudication body on the registration of a practitioner or student, or on an endorsement. Examples of conditions include: • a condition requiring the practitioner to complete specified further education or training within a specified period • a condition requiring the practitioner to undertake a specified period of supervised practice • a condition requiring the practitioner to do, or refrain from doing, something in connection with the practitioner's practice • a condition requiring the practitioner to manage the practitioner's practice in a specified way • a condition requiring the practitioner to report to a specified person at specified times about the practitioner's practice • a condition requiring the practitioner not to employ, engage or recommend a specified person, or class of persons.
Notation	Records a limitation on the practice of a registrant.
Reprimand	A formal rebuke in relation to conduct made by an adjudication body. A reprimand is a chastisement for conduct and must be displayed on the Registers of Practitioners.
Undertaking	An undertaking is given by a practitioner and accepted by the National Board to limit the practice of the profession in the public interest. Also see the definition of 'condition'.

Student registration

In addition to the practising registers for qualified nurses, there are now registers for students undertaking courses leading to qualification as registered healthcare practitioners. Under the *National Law*, students have been registered from 2011. The only student group not to be registered are psychology students, because the Psychology Board of Australia has determined to register these students through provisional registration. There are no fees for student registration.

Any student who is currently enrolled in an approved program of study and is not already registered does not need to apply for registration personally, as AHPRA works directly with education providers to register all relevant students. The other group who require student registration are those who are not enrolled in an approved

program of study, but are undertaking a clinical placement where they do not hold registration in that profession. In this case, it is also the responsibility of the education provider (or the person or organisation providing the clinical placement), and not the individual student, to advise AHPRA of which students need to be registered.

AHPRA advises that the definition of an 'education provider' in the *National Law* is broad. It includes education providers delivering board-approved programs of study leading to registration, and health services and other organisations, and in some cases individuals, who provide clinical experience placements for people who are undertaking clinical training but are not enrolled in a board-approved program of study leading to registration and do not hold registration in Australia in that profession. This includes students from overseas.[22]

The nursing and midwifery board of Australia (NMBA)

The NMBA was established on 1 July 2009 and commenced operation on 1 July 2010. It comprises one practitioner member from each of the jurisdictions (from among whom the Chair is appointed) and four community members. All members hold office for a 3-year term and thus completed their first term on 1 July 2012. All are free to stand for re-election and may serve for a total of three terms before having to step down. The functions of the National Boards are set out in Box 8.2 and do not differ between boards, although not all boards need to exercise all functions. At the time of writing NMBA has three sub-committees that provide the infrastructure for the determinations of the NMBA — the Finance and Governance Committee, the Accreditation Committee and the Policy Committee. As a point of clarification that will be discussed in more detail later, the Accreditation Committee is not the accrediting body for nursing and midwifery education programs. That role is now undertaken by an independent authority — the Australian Nursing and Midwifery Accreditation Council (ANMAC).[23] NMBA meets monthly and is supported in its work by a number of AHPRA staff, including an Executive Officer and a number of designated policy support officers. In addition, NMBA works closely with other senior executive AHPRA staff, both at national and jurisdictional levels. NMBA functions on a hub-and-spoke model, with NMBA providing the strong policy 'hub' and providing oversight and endorsement to the registration and notification decisions of its state and territory boards. In turn, NMBA's state and territory boards provide the strong operational 'spokes' and implement the codes, policies and guidelines developed by the NMBA.

Codes of conduct and ethics and competency standards

The NMBA sets standards for registration and endorsement and also provides guidelines and advice through its website. The NMBA has also endorsed the previous national codes of conduct and ethics for nurses and midwives and the four sets of competency standards for enrolled nurses, registered nurses, registered midwives and nurse practitioners developed by the former peak regulatory body, the Australian Nursing and Midwifery Council (ANMC). These were formerly known as the ANMC Codes and Competency standards but are now badged as the NMBA Codes and Competency standards and are available on the NMBA website.[24] Several of

these former ANMC documents, key pieces of regulatory infrastructure, are due for review and a program of work to undertake this has been agreed by the NMBA. It will be important to keep a watching brief on the website to engage in commentary on the existing documents and to see the new documents when they are developed.

Standards for initial registration

Over the past 2 years the NMBA has been required to set a number of standards under the *National Law* to enable applicants to register. Nurses and midwives who were already registered within their respective jurisdictions transitioned across to the new national scheme, but those who had been off the register and wished to renew, and those who were applying for the first time either because they had just completed an approved course of study in Australia or because they were applying from overseas, are required to meet the new national registration eligibility criteria including certain registration standards, some of which, as already stated, are generic requirements across all professions.

Section 53 of the *National Law* states that an individual is qualified for general registration in a health profession if —

a) the individual holds an approved qualification for the health profession; or
b) the individual holds a qualification the National Board established for the health profession considers to be substantially equivalent, or based on similar competencies, to an approved qualification; or
c) the individual holds a qualification, not referred to in paragraph (a) or (b), relevant to the health profession and has successfully completed an examination or other assessment required by the National Board for the purpose of general registration in the health profession; or
d) the individual —
    i) holds a qualification, not referred to in paragraph (a) or (b), that under this Law or a corresponding prior Act qualified the individual for general registration (however described) in the health profession; and
    ii) was previously registered under this Law or the corresponding prior Act on the basis of holding that qualification.[25]

However, in addition to being qualified for registration, a person must meet a number of other requirements to be eligible for registration. These are set out in section 52 of the *National Law* as follows:

1) An individual is eligible for general registration in a health profession if —
    a) the individual is qualified for general registration in the health profession; and
    b) the individual has successfully completed —
        i) any period of supervised practice in the health profession required by an approved registration standard for the health profession; or

ii) any examination or assessment required by an approved registration standard for the health profession to assess the individual's ability to competently and safely practise the profession; and

c) the individual is a suitable person to hold general registration in the health profession; and

d) the individual is not disqualified under this Law or a law of a co-regulatory jurisdiction from applying for registration, or being registered, in the health profession; and

e) the individual meets any other requirements for registration stated in an approved registration standard for the health profession.[26]

As can be seen under section 52(1)(e), there is an expectation that the profession will set one or more registration standards and that they will be approved by the Ministerial Council. NMBA has developed five registration standards, in addition to the obvious requirement for an approved qualification in nursing or midwifery, as follows:

1) the continuing professional development (CPD) registration standard;
2) the criminal history registration standard;
3) the English language skills (ELS) registration standard;
4) the professional indemnity insurance (PII) registration standard; and
5) the recency of practice (RoP) registration standard.[27]

Each of these standards needs to be met for a nurse or midwife to be eligible for registration. Some standards, such as the criminal history registration standard, are identical across all professions, whereas the CPD, ELS, PII and RoP, whilst being requirements for every profession, may differ in their actual content. Currently the ELS has an agreed minimum standard for all professions.[28] The CPD, PII and RoP standards are discussed briefly below but it is important for applicants to check the NMBA website regularly as these registration standards are frequently reviewed and updated as new research and information becomes available. It is also important to be aware that these are standards for registration as a nurse or midwife and are not to be confused with standards for endorsement as a nurse practitioner (NP) or notation and endorsement as an Eligible Midwife (EM), both of which are discussed separately and both of which take the requirements for eligibility for registration as the first step, after which the requirements for NP and EM are cumulative.

The continuing professional development registration standard

Prior to the introduction of the National Scheme, all jurisdictions except New South Wales had some requirement for continuing professional development, but these have now been standardised nationally. The requirements are the same for enrolled nurses (ENs), registered nurses (RNs) and registered midwives (RMs), although clearly the content will differ. This standard applies to all nurses and midwives who are on the register, but not to nurses and midwives applying to go onto the register. The requirements of the CPD standard are set out in Box 8.3.

BOX 8.3
REQUIREMENTS OF THE CONTINUING PROFESSIONAL DEVELOPMENT REGISTRATION STANDARD[29]

1) Nurses on the nurses' register will participate in at least 20 hours of continuing nursing professional development per year.
2) Midwives on the midwives' register will participate in at least 20 hours of continuing midwifery professional development per year.
3) Registered nurses and midwives who hold scheduled medicines endorsements or endorsements as nurse or midwife practitioners under the National Law must complete at least 10 hours per year in education related to their endorsement.
4) One hour of active learning will equal one hour of CPD. It is the nurse or midwife's responsibility to calculate how many hours of active learning have taken place. If CPD activities are relevant to both nursing and midwifery professions, those activities may be counted in each portfolio of professional development.
5) The CPD must be relevant to the nurse or midwife's context of practice.
6) Nurses and midwives must keep written documentation of CPD that demonstrates evidence of completion of a minimum of 20 hours of CPD per year.
7) Documentation of self-directed CPD must include dates, a brief description of the outcomes, and the number of hours spent in each activity. All evidence should be verified. It must demonstrate that the nurse or midwife has:
   a) identified and prioritised their learning needs, based on an evaluation of their practice against the relevant competency or professional practice standards;
   b) developed a learning plan based on identified learning needs;
   c) participated in effective learning activities relevant to their learning needs;
   d) reflected on the value of the learning activities or the effect that participation will have on their practice.
8) Participation in mandatory skills acquisition may be counted as CPD.
9) The Board's role includes monitoring the competence of nurses and midwives; the Board will therefore conduct an annual audit of a number of nurses and midwives registered in Australia.

Each of the registration standards is set out in a similar format and contains definitions of relevant key terms. For the CPD standard, an explanation of the context of practice is included and is defined as:

> … the conditions that define an individual's nursing or midwifery practice. These include the type of practice setting (for example, healthcare agency, educational organisation, private practice); the location of the practice setting (for example, urban, rural, remote); the characteristics of patients or clients (for example, health status, age, learning needs); the focus of nursing and midwifery activities (for example, health promotion, research, management); the complexity of practice; the degree to which practice is autonomous; and the resources that are available, including access to other healthcare professionals.[30]

In addition to the actual standard, explanatory notes are listed in the 'Frequently Asked Questions' (FAQ) section of the NMBA website and were developed specifically to assist nurses in understanding the requirements of the CPD standard.[31]

The professional indemnity insurance registration standard

Under the new scheme, all healthcare practitioners are required to state on their application and renewal forms that they will not practise their profession unless they have appropriate PII arrangements in place. PII may be obtained in two main ways. First, an employer may agree to indemnify the employee as a part of their employment agreement and as a result of the doctrine of vicarious liability (see Chapter 3 for further discussion on this topic). Second, PII may be purchased as a commercial product, in the same way as any other form of insurance, for nurses and midwives whose employment status indicates that they are not indemnified through the doctrine of vicarious liability. The requirements of the PII standard are set out in Box 8.4.

BOX 8.4
REQUIREMENTS OF THE PROFESSIONAL INDEMNITY INSURANCE ARRANGEMENTS REGISTRATION STANDARD[32]

1) Nurses and midwives, whether employed or self-employed, unless exempted under the National Law, require PII arrangements which cover the full scope of their practice.
2) When applying for registration or renewal of registration, nurses and midwives will be required to declare that they will not practise in their profession unless appropriate PII arrangements are, or will be, in place while they practise nursing or midwifery.
3) Nurses and midwives in different types of practice will require different levels of PII cover, according to their particular level of risk. The following PII cover should be considered:
   a) civil liability cover;
   b) unlimited retroactive cover; and
   c) run-off cover.
4) It is the responsibility of nurses and midwives to understand the nature of the cover under which they are practising.
5) Self-employed nurses and midwives are required to have run-off cover, except those midwives practising privately who are exempt under the National Law.
6) Nurses and midwives who hold insurance cover in their own name are required to retain documentary evidence of their insurance arrangements and to provide it to the Board on request.
7) Self-employed midwives must provide full disclosure of their level of PII to their clients.

PII arrangements are defined in the PII standard as:

> … arrangements that secure, for the practitioner's professional practice, insurance from civil liability incurred by, or loss arising from, a claim that is made as a result of a negligent act, error or omission in the conduct of the practitioner. This type of insurance is available to practitioners and organisations across a range of industries and covers the costs and expenses of defending a legal claim, as well as any damages payable. Some government organisations under policies of the owning government are self-insured for the same range of matters.[33]

PII for privately practising midwives is particularly complex and is discussed later in this chapter in a section exclusively focusing on the regulation of midwives. The PII standard applies to registered and enrolled nurses; registered nurses endorsed as nurse practitioners; and registered midwives. It does not apply to students of nursing and midwifery; nurses and midwives who have non-practising registration and registered midwives who are exempted under the *National Law*.[34] The most recent standard on PII has only been in force since January 2012 and will be subject to review, so it is important that nurses and midwives check the website regularly to obtain the most current advice on these matters — it is a relatively recent development for nursing and midwifery regulatory authorities to become involved in advice about PII. However, in its document, *Guidelines for Professional Indemnity Insurance Arrangements for Midwives*, the NMBA makes the following observations, which are equally applicable to registered and enrolled nurses:

> Professional indemnity insurance provides midwives with insurance from civil liability. This insurance generally includes cover for legal claims for compensation and associated expenses arising from the practice of midwifery. The Board notes that PII arrangements, particularly those provided by employers, may not provide cover for matters of a disciplinary character, which do not usually lead to awards of compensation to patients, clients or other persons who have suffered detriment as a result of a practitioner's action. These matters may involve costs for individual practitioners. The Board does not require practitioners to have insurance cover for matters which do not involve potential of compensation against a practitioner. Examples are unlawful, unauthorised, regulatory or disciplinary matters including breaches of professional codes or ethics. However, the Board recommends that practitioners consider whether they have this cover as part of their PII arrangements, whether as an individual or provided by an employer and if not, whether they wish to obtain it.[35]

The recency of practice (RoP) registration standard

The RoP standard is a requirement which was in force in most jurisdictions except New South Wales in some form prior to national registration. It requires nurses and midwives to have kept up-to-date with their practice for a minimum of 3 months full-time equivalent within the past 5 years. This seems to be a sensible means of ensuring that nurses and midwives stay in touch with professional practice. However, national registration has meant that a single standard for RoP is now being applied, which has led to changes for nurses and midwives in some jurisdictions and, on

occasion, some unhappiness about the requirements.[36] This standard applies to nurses and midwives seeking registration, endorsement of registration or renewal of registration.[37] It does not apply to recent graduates from nursing or midwifery programs in Australia applying for registration for the first time; persons holding student registration; or nurses or midwives holding or applying for non-practising registration. 'Practice' is defined very broadly under the RoP standard as:

> … any role, whether remunerated or not, in which the individual uses their skills and knowledge as a nurse or midwife. For the purposes of this registration standard, practice is not restricted to the provision of direct clinical care. It also includes working in a direct nonclinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession and/or use of their professional skills.[38]

At the time of writing, other professions, particularly medicine, are contesting this definition of practice as being too broad, and an alternative definition is being proposed by some of the other boards that limits practice only to clinical work. However, to date, the NMBA has not joined this debate and has maintained the definition reproduced above. The requirements of the RoP standard are set out in Box 8.5.

BOX 8.5
REQUIREMENTS OF THE RECENCY OF PRACTICE REGISTRATION STANDARD[39]

Nurses and midwives must demonstrate, to the satisfaction of the Board, that they have undertaken sufficient practice, as defined in (2) below, in their professions within the preceding five years to maintain competence.

2) Nurses and midwives will fulfil the requirements relating to recency of practice if they can demonstrate one, or more of the following:
   a) practice in their profession within the past five years for a period equivalent to a minimum of three months full time;
   b) successful completion of a program or assessment approved by the Board; or
   c) successful completion of a supervised practice experience approved by the Board.
3) Practice hours are recognised if evidence is provided to demonstrate:
   a) the nurse or midwife held a valid registration with a nursing or midwifery regulatory authority in the jurisdiction (either in Australia or overseas) when the hours were worked; or
   b) the role involved the application of nursing and/or midwifery knowledge and skills; or
   c) the time was spent undertaking postgraduate education leading to an award or qualification that is relevant to the practice of nursing and/or midwifery.
4) Extended time away from practice due to illness or any type of leave will not be counted as practice.

The requirements of section 2 of the RoP standard are further explained in its FAQs section[40] and are about to be even further elaborated in a *Re-entry to Practice Policy* that has completed its consultation rounds.[41] However, as indicated, this is currently a contentious area of regulation and the reader needs to keep abreast of the most recent developments.

Endorsements under section 94 of the *National Law*

All of the above standards relate to nursing and midwifery entry requirements, but there are also a number of other registration standards that relate to specific categories of registered nurses and midwives and impose requirements on them over and above those for registration. The first is the Endorsement for Scheduled Medicines, established under section 94 of the *National Law*, that states as follows:

> 1) A National Board may, in accordance with an approval given by the Ministerial Council under section 14, endorse the registration of a registered health practitioner registered by the Board as being qualified to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of scheduled medicines if the practitioner —
>
> a) holds either of the following qualifications relevant to the endorsement —
>
> i) an approved qualification;
>
> ii) another qualification that, in the Board's opinion, is substantially equivalent to, or based on similar competencies to, an approved qualification; and
>
> b) complies with any approved registration standard relevant to the endorsement.
>
> **Note.** The endorsement of a health practitioner's registration under this section indicates the practitioner is qualified to administer, obtain, possess, prescribe, sell, supply or use the scheduled medicine or class of medicines specified in the endorsement but does not authorise the practitioner to do so. The authorisation of a health practitioner to administer, obtain, possess, prescribe, sell, supply or use scheduled medicines in a participating jurisdiction will be provided for by or under another Act of that jurisdiction.

Health practitioners registered in certain health professions will be authorised to administer, obtain, possess, prescribe, sell, supply or use scheduled medicines by or under an Act of a participating jurisdiction without the need for the health practitioners to hold an endorsement under this Law:

> 2) An endorsement under subsection (1) must state —
>
> a) the scheduled medicine or class of scheduled medicines to which the endorsement relates; and
>
> b) whether the registered health practitioner is qualified to administer, obtain, possess, prescribe, sell, supply or use the scheduled medicine or class of scheduled medicines; and
>
> c) if the endorsement is for a limited period, the date the endorsement expires.

The NMBA has issued two endorsements under section 94. The first is the Endorsement for Scheduled Medicines for Registered Nurses Registration Standard.[42] This standard originated as an interim standard developed to address a need for nurses in rural and isolated practice in Queensland to obtain, supply and administer Schedule 2, 3, 4 and 8 medicines. It was not intended to be reviewed until 12 months after its release, but it is currently under review to develop a nationally consistent standard that addresses the issues of high complexity work in areas of low supervision where registered nurses are required to obtain, supply and administer Schedule 2, 3, 4 and 8 medicines for nursing practice. As indicated in the note in section 94 above, even where a registered nurse is endorsed as being qualified under this standard, the relevant legislation to authorise the endorsed registered nurse to undertake those activities still resides with the employing jurisdiction, usually under relevant drugs and poisons legislation. The second endorsement under section 94 is the Endorsement for Scheduled Medicines for Midwives Registration Standard.[43] This endorsement is discussed later in this chapter in the special section on the regulation of midwifery.

Endorsement as a nurse practitioner under section 95

For the first time in Australia under the new National Scheme there is a nationally consistent standard for endorsement as a nurse practitioner (NP).[44] Section 95 of the *National Law* states that:

1) The Nursing and Midwifery Board of Australia may endorse the registration of a registered health practitioner whose name is included in the Register of Nurses as being qualified to practise as a nurse practitioner if the practitioner —
   a) holds either of the following qualifications relevant to the endorsement —
      i) an approved qualification;
      ii) another qualification that, in the Board's opinion, is substantially equivalent to, or based on similar competencies to, an approved qualification; and
   b) complies with any approved registration standard relevant to the endorsement.
2) An endorsement under subsection (1) must state —
   a) that the registered health practitioner is entitled to use the title 'nurse practitioner'; and
   b) any conditions applicable to the practice by the registered health practitioner as a nurse practitioner.

Section 95(1)(b) provides for the NMBA to develop a registration standard relevant to the endorsement — it is the Endorsement as a Nurse Practitioner Registration Standard.[45] The standard applies to all applicants seeking endorsement as a nurse practitioner. The requirements of the standard are set out in Box 8.6.

As with the provisions under section 94, the authority to prescribe medicines is conferred under the relevant drugs and poisons legislation of the Australian state or territory in which the NP practises. The conditions under which each authority is granted and the scope of that authority will depend on the requirements of the

BOX 8.6
REQUIREMENTS OF THE ENDORSEMENT AS A NURSE PRACTITIONER REGISTRATION STANDARD[46]

To be eligible for endorsement as a nurse practitioner, the registered nurse must be able to provide evidence to demonstrate all of the following:

a) current general registration as a registered nurse with no conditions on registration relating to unsatisfactory professional performance or unprofessional conduct;

b) the equivalent of three (3) years' full-time experience in an advanced practice nursing role, within the past six (6) years from the date when the complete application seeking endorsement as a nurse practitioner is received by the Board;

c) successful completion of a Board-approved nurse practitioner qualification at Master's level or education equivalence as determined by the Board;

d) compliance with the Board's *National Competency Standards for the Nurse Practitioner* which can be accessed from the Board's website at www.nursingmidwiferyboard.gov.au under *Codes, Guidelines and Statements*; and

e) compliance with the Board's registration standard on continuing professional development.

specific legislation in each state or territory. These may range from a blanket authority limited by the practitioner's scope of practice, to an authority based on a formulary or protocol, or related to a specific context of practice (such as only being applicable in a certain practice setting). To specify a distinct formulary of medicines for each area of specialty of NPs is outside the provisions of the *National Law*. However, clearly, failure of a nurse practitioner to practise and prescribe within this scope of practice will result in the NMBA taking disciplinary action.[47]

The advice above is taken from a set of guidelines developed by the NMBA explaining (*inter alia*) the processes and evidence required both for initial and ongoing endorsement as a NP.[48] Previously, each jurisdiction had its own specific processes and requirements to enable a person to be recognised as a NP and the process of developing a standard across all jurisdictions has been quite complex. The NMBA has developed a rigorous NP Safety and Quality Framework (NP SQF) that integrates the requirements for NPs to provide a robust regulatory framework both for the public and also for the NPs themselves. In addition, it ensures that NPs who are in private practice and have access to the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme have clarity and support to practise in their roles with safety and quality. The elements of the NP SQF are as follows:

- scope of practice;
- codes of professional conduct and ethics;
- national competency standards;
- annual declaration;
- NMBA audit process;

- mandatory reporting;
- notification and management of performance, conduct or health matters;
- co-regulatory requirements of Medicare and the NMBA;
- prescribing authority and compliance with relevant state and territory legislation, and collaborative arrangements.[49]

In relation to the scope of practice of NPs, the NMBA has issued a Position Statement[50] which clarifies expectations in relation to recognising the extent and limitations of their scope of practice. The statement provides important advice for NPs (and indeed, can to some extent be extrapolated to all nurses and midwives in relation to scope of practice).

The NMBA recognises that nurses obtain and develop specialist qualifications and expertise throughout the course of their careers. It is an expectation that nurse practitioners are competent in the specific area of practice required to meet the needs of their client group. Nurses seeking endorsement as NPs are expected to have completed 3 years' advanced practice in their specific area, and in accordance with the Safety and Quality Framework (SQF) included in the guidelines on endorsement as a nurse practitioner (published at www.nursingmidwiferyboard.gov.au under *Codes, Guidelines and Statements*) before applying for endorsement. Employers should be aware of the scope of practice of nurse practitioners and ensure that they are employed appropriately.

The NMBA wishes to advise that, given the dynamic nature of healthcare and the evolving role of nurse practitioners, a scope of practice notation will not be included on the endorsement of nurse practitioners. In addition to the guidelines on endorsement mentioned above, the board has approved a registration standard on endorsement as a nurse practitioner (published at www.nursingmidwiferyboard.gov.au under *Registration Standards*) to provide clear direction and guidance to ensure that all nurse practitioners are practising safely and to a professional standard that protects the health and safety of the public.[51]

Nurse practitioners' access to the Australian Government Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS)

Endorsement as a nurse practitioner with the NMBA confers eligibility to apply for approval by the Health Minister as a 'participating nurse practitioner' under the *Health Legislation Amendment (Midwives and Nurse Practitioners) Act 2010* (Cth) Schedule 1, item 7, subsection 3(1). A participating nurse practitioner has access to the Australian Government Medicare Benefits Schedule (MBS) and, where the nurse practitioner has an authority to prescribe, the Pharmaceutical Benefits Scheme (PBS). These arrangements will enable patients of nurse practitioners who are approved MBS and/or PBS participants, to access certain MBS rebates and PBS prescriptions. The following information is taken from the NMBA's NP SQF[52] and explains access to the MBS and PBS and the new collaborative arrangements that are in place under the *Health Legislation Amendment (Midwives and Nurse Practitioners) Act 2010* (Cth).

The nurse practitioner needs to apply to Medicare Australia for a provider and/or prescriber number. The discretion to authorise access to the MBS and PBS remains with Medicare Australia and the process of authorisation through Medicare is a process additional to the Board's endorsement process. As part of the co-regulatory requirements of the Board and Medicare Australia, any issues related to conduct, performance or health that may impact on the performance of an individual nurse practitioner, as a prescriber or provider of Medicare services or medicines, is notified by either co-regulatory body to the other. For example, if Medicare Australia has cause to investigate a particular provider, the Board will be notified of that investigation and the other way around. From a co-regulatory perspective, Medicare Australia continues its important monitoring and review role. This is designed to ensure services and medicines provided by any health professional with access to the MBS and PBS are effective, efficient, appropriate and within benchmarking limits. However, should there be an issue related to performance, health or conduct of a nurse practitioner, the Board is the professional regulatory authority to which a notification will be referred. The Board will oversee the assessment of the notification and any subsequent investigation or disciplinary action.

All nurse practitioners are required to engage in clinical collaboration in compliance with the *National Competency Standards for the Nurse Practitioner* (ANMC 2005; adopted NMBA 2010). However, in addition to this pre-existing requirement, nurse practitioners who are authorised under the *Health Legislation Amendment (Midwives and Nurse Practitioners) Act 2010* (Cth), and who are assigned a Medicare provider number or PBS prescriber number have further requirements for collaboration as described in sections 5–7 of the *National Health (Collaborative Arrangements for Nurse Practitioners) Determination 2010* (Cth). These specific collaborative arrangements are available online from the Commonwealth of Australia Law website www.comlaw.gov.au.[53]

The regulation of midwifery

Background

For the first time in Australia midwifery has been recognised nationally as a profession distinct from, but professionally aligned with, nursing. This is congruent with many other developed countries that recognise both direct entry and post-graduate pathways into nursing and midwifery.[54] The major difference in the new scheme in Australia is that there are now separate registers for nursing and midwifery, which means that people who have a sole qualification in midwifery are able to register solely as a midwife. Formerly in some jurisdictions it was not possible to do this, and it created difficulties for overseas qualified midwives who did not have a nursing qualification, but who may otherwise have wished to practise midwifery in Australia. Some Australian universities now offer direct entry midwifery programs and there is evidence from countries with direct entry midwife training that show higher

midwife retention than where nurse training is required first.[55] In addition, the option to be on the non-practising register will mean that, from a workforce perspective, there will be a clear idea of the size of the practising midwifery workforce for the first time, rather than simply having a sense of how many people hold a midwifery qualification.

The requirements to be eligible to register as a midwife are exactly the same as to be eligible to register as a nurse: namely, the application must meet the eligibility requirements set out under section 52 of the *National Law*. The only difference is that the approved program of study referred to in section 53 is in midwifery, rather than nursing, and that the recency of practice relates to midwifery practice. Upon renewal, the requirements for continuing professional development also need to relate to a midwifery context of practice, although if a midwife is also registered as a nurse and any CPD undertaken for nursing also relates to midwifery practice, it can be claimed for both contexts.[56]

Where the major differences occur are in relation to the Registration Standard for Eligible Midwives[57] established under section 38(2) of the *National Law* and the Registration Standard for Endorsement for Scheduled Medicines for Midwives under section 94.[58] There has not been a great deal of support from the midwifery profession for the concept of endorsing the midwife practitioner, as philosophically this did not seem to fit with the midwifery model of practice.[59] However, in 2008, the Federal Government, as a result of a major review of maternity services in Australia,[60] recommended maternity reform legislation to provide MBS and PBS benefits, as well as professional indemnity insurance, for services provided by appropriately qualified and experienced midwives, known as eligible midwives (EMs). The arrangements did not cover planned homebirths. The nature of the access to MBS and PBS was introduced at the same time as the access reforms for nurse practitioners, and some of the provisions are very similar. However, there are some specific differences which relate particularly to the process for notating EMs, the scheduled medicines endorsement for EMs, the PII requirements for privately practising midwives (PPMs), and the PII exemptions for PPMs offering homebirths. Each of these matters is discussed below in turn.

Eligible Midwives Registration Standard under section 38(2)

It is important to understand that the *National Law* makes no reference to eligible midwives, as they were a creation of the Maternity Services Review. However, because they are to have access to MBS and PBS, it was considered necessary that they should be regulated through the professional regulatory mechanism prior to endorsement. This requires the midwife to be recognised as an EM through a notation on their registration. The notation reads as follows:

> An eligible midwife competent to provide pregnancy, labour, birth and postnatal care and qualified to provide the associated services and order diagnostic investigations required for midwifery practice, in accordance with relevant State and Territory legislation.[61]

Notation as an EM applies to a class of, rather than all, registered midwives. Having a notation made on the Register of Midwives as an eligible midwife indicates

(as stated above) that the applicant is qualified to provide pregnancy, labour, birth and postnatal care to women and their infants. It is the fact that this includes the capacity to provide associated services and order diagnostic investigations appropriate to the eligible midwife's scope of practice that makes the notation critical. All midwives should be able to 'provide pregnancy, labour, birth and postnatal care' to women and their infants: that is the scope of practice of any midwife. However, not all midwives practice to their full scope. Some choose, after qualifying, only to work in antenatal or postnatal or a labour ward. This means they do not have the opportunity to provide care within a continuity of care model for a woman and her child. In addition, the NMBA currently makes a distinction between being notated as an EM and being endorsed to prescribe scheduled medicines in accordance with relevant state and territory legislation. A notation as an EM may provide access to MBS but access to PBS is only available once an endorsement for scheduled medicines under section 94 has been attained. The section 94 endorsement is discussed further on in this chapter. The requirements for registration as an EM are set out in Box 8.7.

A number of factors regarding the eligible midwife requirements are worthy of note. First, a newly graduated beginning midwife cannot be an EM, since EMs require the equivalent of 3 years' full-time midwifery experience after initial registration as a midwife. Second, they need to be currently competent to provide

BOX 8.7
REQUIREMENTS FOR REGISTRATION AS AN ELIGIBLE MIDWIFE[62]

To be entitled to be identified as an eligible midwife, a midwife must be able to demonstrate, at a minimum, all of the following:

a) current general registration as a midwife in Australia with no restrictions on practice;
b) midwifery experience that constitutes the equivalent of three years' full-time post initial registration as a midwife;
c) current competence to provide pregnancy, labour, birth and postnatal care to women and their infants;
d) successful completion of an approved professional practice review program for midwives working across the continuum of midwifery care;
e) 20 additional hours per year of continuing professional development relating to the continuum of midwifery care;
f) formal undertaking to complete within 18 months of recognition as an eligible midwife, or the successful completion of:
    i) an accredited and approved program of study determined by the Board to develop midwives' knowledge and skills in prescribing; or
    ii) a program that is substantially equivalent to such an approved program of study, as determined by the Board.

midwifery care in all aspects of midwifery. The 'approved professional practice review program' is not necessarily a formal qualification such as a Masters degree — unlike the requirement for NP endorsement — but again, it seeks to assess midwives to be competent across the continuum of care. Indeed, a successful outcome from (d), in Box 8.7, is considered to be evidence of (c).[63]

The 'approved professional practice review program' is defined as:

> … a formal professional practice review program for midwives approved by the Nursing and Midwifery Board of Australia (the Board), designed to review evidence of performance over time across the continuum of midwifery care, including self-assessment against the *Code of Professional Conduct for Midwives in Australia*, the *Code of Ethics for Midwives in Australia*, the Australian Nursing and Midwifery Council (ANMC) *National Competency Standards for the Midwife*, the Australian College for Midwives (ACM) *National Midwifery Guidelines for Consultation and Referral*, and may include clinical review based on information detailing de-identified client data on outcomes, including adverse events and complaints; consultation, review and referral to other health professionals; review of client satisfaction; other forms of professional review and assessment (by employers, professional organisations and peers); ongoing professional development across the continuum of midwifery care; and timely and correct provision of maternity data to jurisdictional data collections. A list of approved midwifery practice review programs will be published on the Board's website.[64]

Note that (e) — the CPD requirement — asks for 20 additional hours per year of continuing professional development relating to the continuum of midwifery care. This additional requirement is double the 10 hours expected of NPs in their CPD per year. The requirement for 20 hours was determined by the NMBA in consultation with midwifery professional leaders and was in response to the fact that there is no requirement for a higher degree to become an EM, unlike the NP endorsement under section 95. Finally, (f) sets up an undertaking to complete 'an accredited and approved program of study determined by the Board to develop midwives' knowledge and skills in prescribing', or its equivalent, within 18 months of notation as an EM. This requirement is purely pragmatic as, at the time of developing the registration standard, there were no available Board-approved courses. At the time of writing, the first programs are under assessment with the new national accreditation body, ANMAC, but at the time of developing the registration standard it was not possible to make that an immediate requirement. However, it was necessary to have the registration standard for EMs accessible and established because of the PII requirements for privately practising midwives, as is discussed below.

Registration Standard for Endorsement for Scheduled Medicines for Midwives under section 94

The registration standard for endorsement for scheduled medicines for midwives under section 94 of the *National Law* is the means by which EMs are able to

prescribe selected medications. The wording to appear on the register is 'Endorsed as qualified to prescribe schedule 2, 3, 4 and 8 medicines required for midwifery practice across pregnancy, labour, birth and postnatal care, in accordance with relevant State and Territory legislation'.[65] The endorsement applies to a class of midwives and not to all midwives and the scope of the endorsement is that the midwife is 'qualified to prescribe schedule 2, 3, 4 or 8 medicines appropriate for midwifery practice across pregnancy, labour, birth and postnatal care within the meaning of the current poisons standard under section 52D of the *Therapeutic Goods Act 1989* (Cth), and in compliance with relevant State and Territory legislation'.[66] The qualifications for endorsement are set out in Box 8.8.

In comparing the two standards, there is only one difference between the requirements for notation as an EM and the qualifications for endorsement — whereas the requirements for notation as an EM offer the option of undertaking formal study with a view to completing it within 18 months of recognition as an EM, under (f) in the endorsement standard, the requirement is for the successful completion of that study. Thus, an EM cannot prescribe until they have had extra education to prepare them to do so. What medicines the EM will be able to prescribe depends on the relevant jurisdictional poisons legislation but there is a formulary for midwifery prescribing that the NMBA has endorsed and that is on the NMBA website.

BOX 8.8
QUALIFICATIONS FOR ENDORSEMENT FOR SCHEDULED MEDICINES FOR MIDWIVES[67]

To be entitled to be endorsed for scheduled medicines, a midwife must be able to demonstrate, at a minimum, all of the following:

a) current general registration as a midwife in Australia with no restrictions on practice;
b) midwifery experience that constitutes the equivalent of three (3) years' full-time post-initial registration as a midwife;
c) current competence to provide pregnancy, labour, birth and postnatal care to women and their infants;
d) successful completion of an approved professional practice review program for midwives working across the continuum of midwifery care;
e) 20 additional hours per year of continuing professional development relating to the continuum of midwifery care;
f) successful completion of:
    i) an accredited and approved program of study determined by the Board to develop midwives' knowledge and skills in prescribing; or
    ii) a program that is substantially equivalent to such an approved program of study, as determined by the Board.

Professional indemnity insurance requirements for privately practising midwives

The *National Law* requires a registered healthcare practitioner not to practise the healthcare profession in which the practitioner is registered unless appropriate professional indemnity insurance arrangements are in force.[68] This is not usually a problem for midwives who are employees of large organisations due to the doctrine of vicarious liability. However, it had the potential to create a problem for midwives in private practice, as from 2001 to 2008 privately practising midwives (PPMs) were unable to obtain professional indemnity insurance in Australia and, if they wished to continue providing private homebirth services, were fundamentally forced to practise midwifery uninsured.[69]

Since 2008, government-subsidised and other insurance products have been available to midwives working in private practice. However, none of the insurance products offered covers the actual intrapartum aspects of homebirth and it did not appear to be possible to obtain such cover. This lacuna had the potential to remove the option of a homebirth for women unless some alternative arrangements could be made. For this reason, from 1 July 2010, under section 284 of the *National Law*, there is a 2-year exemption from the requirement for PPMs to hold PII for homebirths. However, PPMs who are granted this exemption are required to meet a set of specified requirements under section 284(1)(b) and (c). Notwithstanding this exemption, PPMs must have insurance for providing antenatal and postnatal services, regardless of the birth setting. PII arrangements that midwives are advised to consider include civil liability cover, unlimited retroactive cover and run-off cover.[70]

The Department of Health and Ageing explains that the Australian Government has contracted an insurer to provide professional indemnity insurance to eligible midwives. The term 'eligible midwife' here has the same meaning and implications as the NMBA's definition — namely that these midwives will need to meet the registration standard for EMs to qualify for government-subsidised PII (see Box 8.7).[71]

PPMs who are granted this exemption are also required to meet a set of specified requirements under section 284(1)(b) and (c). Section 284(1)(b) states that 'informed consent has been given by the woman in relation to whom the midwife is practising private midwifery'. The NMBA explains that 'informed consent must be given by the woman who is the client of the midwife who is in private practice' and defines informed consent as 'written consent given by a woman after she has been given a written statement by a midwife that includes a statement that appropriate PII arrangements will not be in force in relation to the midwife's practice of private midwifery in attending a homebirth and any other information required by the Board'.[72]

Section 284(c) and (c)(i) require the midwife to comply 'with any requirements set out in a code or guideline approved by the National Board under section 39 about the practise of private midwifery, including any requirement in a code or guideline about reports to be provided by midwives practising private midwifery'. The NMBA has a number of codes and guidelines specifically for midwives, some of which were discussed earlier, such as the *Code of Professional Conduct for Midwives*

in Australia, the *Code of Ethics for Midwives in Australia* and the *National Competency Standards for the Midwife*. Other advisory documents and guidelines, such as the *Professional Boundaries* documents and decision-making frameworks are discussed briefly later in this chapter.

Section 284(c)(ii) requires midwives in private practice to meet the requirements detailed in these guidelines with regard to safety and quality for the PII exemption. The original Safety and Quality Framework (SQF) that was developed for the purpose of enabling PPMs to meet this criterion was adopted by the NMBA and is currently due for review. Notwithstanding this review, the need for a SQF is written into the legislation and therefore NMBA will be required to publish a revised SQF. The NMBA initially used the SQF developed by the Victoria Government at the request of the Australian Health Ministerial Advisory Council (AHMAC) and incorporated the principles of the SQF into all new documents relating to midwifery practice. These include the Guidelines and Assessment Framework for the Eligible Midwives and Endorsement for Scheduled Medicines Registration Standard. The principles underpinning the SQF will continue to be used in all future policy documents relating to midwifery.[73] The SQF is not to be considered in isolation either. The document cites a number of other publications relating to midwifery practice.

The framework is written to ensure safe, high-quality care of the baby and the woman choosing to birth at home with a privately practising midwife. It is not a mechanism for determining the eligibility of midwives to gain access to the Medicare or Pharmaceutical Benefits Schemes. The Australian Council of Midwives Consultation and Referral Guidelines and the principles and practices outlined in the draft NHMRC National Guidance on Collaborative Maternity Care form a major element of the Safety and Quality Framework. The principles articulated in 'Primary Maternity Services in Australia' (AHMAC, 2008) underpin the provision of primary maternity care in Australia and inform the main principles of the Safety and Quality Framework.[74]

The SQF makes a number of statements relating to a woman's right to choose her place of birth and later sets out a table by which evidence of compliance with the SQF can be ascertained for the purposes of granting an exemption. These are organised under the principles of consumer value, clinical performance and evaluation, clinical risk and professional evaluation.[75] In addition, the SQF sets out a number of considerations and criteria related to homebirth that the PPM is expected to address.

Distance and time to travel to an appropriately staffed maternity service should be considered when assessing suitability for this option of care. These factors are in addition to undertaking an assessment of risk for this birthing option. Women with a singleton pregnancy, cephalic presentation, at term and free from any significant pre-existing medical or pregnancy complications are those identified in the ACM guidelines as clearly meeting criteria for midwifery-led care. When PPMs are the primary carers for women who fall outside of these criteria, the consultation and referral pathways must be documented and followed. Clearly articulated and documented plans of escalation and collaboration are integral to the provision of safe high-quality care leading to positive outcomes for mothers and babies. PPMs are

required to document advice provided to women in their care about the midwifery scope of practice, risks and escalation processes. In addition, they will enlist the services of another registered maternity care professional to provide a second opinion in situations where the woman chooses not to follow clinical advice about the need for interventions or transfer. A written record of these processes is essential to verify adherence to the framework in the event of any adverse outcome and/or subsequent legal action or professional investigation.[76]

There have been significant developments in the regulation of midwifery since the previous edition of this textbook. These are clearly quite complex, but it is exciting that Australian midwives are now able to be recognised as professionals in their own right and that women are having increased choice in maternity services. Despite these specific differences, there are also many similarities in the law regulating nurses and midwives, and indeed other healthcare professionals. The NMBA has adopted and/or developed a number of other guidelines for nurses and midwives, some of which make separate reference to the two professions and others which are generic.

Other NMBA guidelines for nurses and midwives

The NMBA has also endorsed a number of evidence-based guidelines and advisory documents that were commissioned by the Australian Nursing and Midwifery Council, the former peak regulatory body for nursing and midwifery in Australia. These are now badged as NMBA documents and included on the NMBA website under *Codes, Guidelines and Statements*.[77] Under *Codes and Guidelines*, in addition to the Competency Standards discussed previously, the following documents are available:

- Decision-making frameworks for nurses and midwives (discipline-specific);
- Guidelines for advertising of registered health professionals (generic);
- Guidelines for mandatory notifications (generic);
- Principles for the assessment of national competency standards (generic);
- Professional boundaries advisory documents (discipline-specific).[78]

Under *Position Statements*, some of which have already been discussed in this chapter, the NMBA has issued statements on the scope of practice of NPs; midwives in private practice; midwife practitioners; and concurrent registration as a registered and enrolled nurse; and has endorsed the June 2011 Australian College of Midwives Position Statement on Homebirth.[79] Also, under *FAQ and Fact Sheets*, NMBA has issued advice on English Language Skills (x2); recency of practice; registration as a nurse or midwife; CPD; enrolled nurse medication administration; NP notation; visa requirements for international nursing students; title protection; and social media information.[80] All of these documents together form the professional practice framework for nurses and midwives, who should be familiar with those pertaining to their scope of practice. In particular, the decision-making framework and professional boundaries documents are equally as important as the codes of conduct and ethics and competency standards in terms of helping beginning practitioners understand their responsibilities to the public and their respective professions.

Notifications and complaints about nurses and midwives

Protecting the public means that the public in general (including other healthcare professionals) have a right (and in some instances a duty) to notify the relevant registration authority if they have concerns about a healthcare practitioner's conduct. Perhaps his or her conduct appears in some way to be putting the public at risk, or their health could be affecting his or her ability to practise safely, or there may be concerns about his or her clinical competence or performance. AHPRA provides advice on the types of conduct, health or performance matters that may prompt a member of the public to make a notification. These are set out in Box 8.9.

BOX 8.9
DEFINITIONS FOR THE PUBLIC REGARDING NOTIFICATIONS IN RELATION TO HEALTHCARE PRACTITIONERS' CONDUCT, HEALTH AND PERFORMANCE[81]

Conduct

Activities considered as breaches of professional conduct are categorised as unprofessional conduct, professional misconduct and notifiable conduct.

Unprofessional conduct

Unprofessional conduct includes:

- breach of the *National Law*
- breach of a registration condition or undertaking
- conviction for an offence that may affect suitability to continue practice
- providing health services that are excessive, unnecessary or not reasonably required
- influencing, or attempting to influence, the conduct of another registered health practitioner that may compromise patient care
- accepting a benefit as inducement, consideration or reward, for referrals or recommendations to use a health service provider
- offering or giving a person a benefit, consideration or reward, in return for providing referrals or recommendations to use a health service provider
- referring a person to, or recommending another health service provider, health service or health product, if there is a financial interest, unless the interest is disclosed.

Professional misconduct

Professional misconduct includes:

- conduct that is substantially below the standard reasonably expected of a registered healthcare practitioner of an equivalent level of training or experience
- more than one instance of unprofessional conduct
- conduct that is not consistent with being a fit and proper person to hold registration in the profession.

Notifiable conduct

(discussed separately)

Health

Practitioners are health impaired if they have a physical or mental impairment, disability, condition or disorder that detrimentally affects, or is likely to detrimentally affect their capacity to practise their profession.

If health practitioners or students have a health impairment, conditions may be imposed upon their registration to ensure that they are able to practise safely.

Impairment is defined as a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence), that detrimentally affects or is likely to detrimentally affect a:

- registered health practitioner's capacity to safely practise the profession
- student's capacity to undertake clinical training.

Performance

The professional performance of a registered practitioner is defined to be unsatisfactory if it is below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

Health practitioners and students must be able to maintain satisfactory standards of performance that are appropriate to their profession.

The professional performance of a registered practitioner is defined to be unsatisfactory if the knowledge, skill or judgment possessed, or care exercised, is below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

A notification can be made electronically, by mail, by telephone or in person. There are forms that need to be completed but AHPRA staff can assist the public to complete these where necessary. When a notification is received, AHPRA will assess it to determine whether a board must consider taking immediate action to protect public health or safety. This may result in suspending or imposing conditions on the registration status of a student or practitioner. If immediate action is not required, AHPRA will assess the notification thoroughly to enable the relevant board to make an informed decision about it. Each investigation is tailored to the notification received, and complex matters take more time. AHPRA aims to complete most investigations within 6 months.[82]

There are a number of stages to the notification process, and it is useful to reproduce the AHPRA advice on these so that the reader can have a clear idea of the complexity of the process. The advice is set out in full in Box 8.10.

There is also a requirement under the *National Law* for mandatory notifications in some situations. Practitioners and employers must report a registrant who they believe has engaged in notifiable conduct. This is a new requirement for nurses and midwives although other healthcare professionals have been subject to this requirement previously. The belief must be formed through the practice of the profession.

BOX 8.10
STAGES OF THE NOTIFICATION/COMPLAINT PROCESS[83]

All notifications/complaints pass through stages 1 and 2, and depending on the outcome of the preliminary assessment may pass through any of the following stages, 3 to 5.

Stage 1: Receipt of notification/complaint

AHPRA receives the notification/complaint either by online form, hardcopy form letter or telephone.

Stage 2: Preliminary assessment

A preliminary assessment determines if the matter will be handled by AHPRA or referred to another health complaints entity. If the location of the incident was in New South Wales, the matter is referred to a New South Wales Authority (NSW Health Care Complaints Commission and Medical Council of New South Wales) for action.

Preliminary assessment outcome

The outcome of the preliminary assessment may be for the board to:

- take immediate action on the practitioner's or student's registration
- investigate the notification
- request a health assessment of the practitioner or student or a performance assessment of the practitioner
- refer the matter to a health or performance panel hearing
- refer the matter to a tribunal hearing
- issue a caution
- accept undertakings
- impose conditions
- take no further action.

Stage 3: Investigation

An investigation may need to be conducted to determine the appropriate course of action, which may be to:

- take immediate action
- request a health or performance assessment
- refer the matter to a health or performance panel hearing
- refer the matter to a tribunal.

A decision may be made to:

- issue a caution
- accept undertakings
- impose conditions
- refer all or part of the notification to another body
- take no further action.

Where an undertaking or condition applies, the registrant will be subject to monitoring to ensure compliance.

Stage 4: Panel hearing

A panel hearing will be conducted to determine the appropriate course of action, which may be to refer the matter to a tribunal.

A decision may be made to:

- issue a caution or reprimand (performance and professional standards panel only)
- impose conditions
- refer to another body
- suspend (only by a Health Panel)
- take no further action.

Where an undertaking or condition applies, the registrant will be subject to monitoring to ensure compliance.

Stage 5: Tribunal hearing

A tribunal hearing will be conducted to determine the appropriate course of action, which may be to:

- issue a caution or reprimand
- impose conditions
- fine the registrant
- suspend registration
- cancel registration
- take no further action.

Where an undertaking or condition applies, the registrant will be subject to monitoring to ensure compliance. Tribunal hearing outcomes are made available to the public.

Under section 140, notifiable conduct, in relation to a registered healthcare practitioner means that the practitioner has:

a) practised the practitioner's profession while intoxicated by alcohol or drugs; or
b) engaged in sexual misconduct in connection with the practice of the practitioner's profession; or
c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or
d) placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

The AHPRA website provides useful information in relation to notifications, but it is important to remember that the advice on the NMBA website in relation to professional standards is there specifically to protect the public. Practitioners who practise within their professional practice framework, whilst not being immune from public dissatisfaction or concern, would be less likely to attract disapprobation.

The New South Wales complaints system

In New South Wales, although registration and accreditation functions for nursing and midwifery are managed centrally by the NMBA and ANMAC respectively, the Government opted to retain its pre-existing complaints handling, investigating and prosecuting mechanisms. To do this, it established, from 1 July 2010, a complaints handling authority — the Health Professionals Council Authority (HPCA) — to provide administrative and secretarial support to the 10 healthcare professionals councils in the performance of their regulatory and legislative functions under the National Registration and Accreditation Scheme, and in their primary role to protect the public.

The 10 councils are the: Chiropractic Council of New South Wales; Dental Council of New South Wales; Medical Council of New South Wales; Nursing and Midwifery Council of New South Wales; Optometry Council of New South Wales; Osteopathy Council of New South Wales; Pharmacy Council of New South Wales; Physiotherapy Council of New South Wales; Podiatry Council of New South Wales; and Psychology Council of New South Wales.

The HPCA is an administrative body of the Health Administration Corporation. It is self-funded from the regulatory proportion of the annual registration fees paid by healthcare practitioners practising in New South Wales. HPCA staff are employed by the Director-General of NSW Health, to whom the Director of the HPCA reports. Whilst the processes of who conducts the investigation and the prosecution differ, many of the requirements are the same as for the national scheme, including the requirement for mandatory notification. The HPCA website provides valuable and comprehensive advice for nurses and midwives in New South Wales regarding the processes in that state in the FAQ section.[84]

The accreditation of nursing and midwifery courses

Prior to the national scheme coming into operation, each jurisdiction would accredit its own courses leading to registration or enrolment as a nurse or registration as a midwife. Under the national scheme, a new independent accreditation authority for nursing and midwifery has been established, the Australian Nursing and Midwifery Accreditation Council (ANMAC). Whilst it is beyond the scope of this chapter to describe this work in detail, it is important for nurses and midwives to understand that the approval of programs leading to qualifications that go onto the registers is rigorous, systematic, and now nationally consistent. Information about ANMAC is available on the Council's website.[85]

CONCLUSION

It is evident that there have been substantial and exciting changes to the regulation of nurses and midwives in Australia. The new national scheme is still in its early days, so it is important that nurses and midwives check the relevant websites on a regular basis to keep abreast of developments.

Endnotes

Note: All links given below were last accessed on 16 February 2012.

1) Australian Health Practitioner Registration Authority (AHPRA), *Who we are*, 2012, http://www.ahpra.gov.au/About-AHPRA/Who-We-Are.aspx.
2) Great Britan Department of Health, *Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century*, HMSO, Norwich, 2007, p 16.
3) Levi-Faur D, *Handbook on the Politics of Regulation*, Edward Elgar Publishing, Cheltenham, 2012, p 459.
4) *Health Practitioner Regulation National Law Act 2009* (Qld), Schedule, Part 2, s 11.
5) *COAG Standing Council on Health*, http://www.ahmac.gov.au/site/home.aspx.
6) *Health Practitioner Regulation National Law Act 2009* (Qld), Schedule, Part 3, s 22.
7) *Health Practitioner Regulation National Law Act 2009* (Qld), Schedule, Part 4, s 29.
8) Health Practitioner Council Authority, http://www.hpca.nsw.gov.au/About-Us/default.aspx.
9) *Health Practitioner Regulation National Law Act 2009* (Qld), Schedule, Part 4, s 25.
10) However, it is the state board of the Nursing and Midwifery Board of Australia (NMBA) that receives and processes requests for registration and/or endorsement.
11) *Health Practitioner Regulation National Law Act 2009* (Qld), Schedule, Part 5, s 35.
12) *Health Practitioner Regulation National Law Act 2009* (Qld), Schedule, Part 1, s 3(a).
13) *Health Practitioner Regulation National Law Act 2009* (Qld), Schedule, Part 1, s 3(b).
14) *Health Practitioner Regulation National Law Act 2009* (Qld), Schedule, Part 5, s 36.
15) *Health Practitioner Regulation National Law Act 2009* (Qld), Schedule, Part 1, s 3(c).
16) Except in Western Australia, where there are slightly different requirements for mandatory notifications.
17) AHPRA, *Registers of Practitioners*, 2012, http://www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx?m=Search.
18) *Health Practitioner Regulation National Law Act 2009* (Qld), Schedule, Part 7, s 73.
19) NMBA, *Recency of Practice FAQ*, 2010, http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ.aspx.
20) Australian College of Midwives Inc., *ACMI Position Statement: Midwifery and the Nurse Practitioner Project*, ACMI, Canberra, 2005.
21) AHPRA, *Glossary*, 2012, http://www.ahpra.gov.au/Support/Glossary.aspx#C.
22) AHPRA, *Student Registrations*, 2012, http://www.ahpra.gov.au/Registration/Student-Registrations.aspx.
23) Australian Nursing and Midwifery Accreditation Council, *ANMAC Home*, 2012, http://www.anmc.org.au/.
24) NMBA, *Codes, Guidelines and Statements*, 2012, http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx.
25) *Health Practitioner Regulation National Law Act 2009* (Qld), Schedule, Part 7, s 53.
26) *Health Practitioner Regulation National Law Act 2009* (Qld), Schedule, Part 7, s 52.
27) NMBA, *Registration Standards*, 2012, http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx.
28) Ibid. Also, see the *English Language Skills Registration Standard* effective 19 September 2011, which will apply to all new applicants.
29) NMBA, *Continuing Professional Development Registration Standard*, 2010, p 1, http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx.
30) Ibid.
31) NMBA, *Continuing Professional Development FAQ for Nurses and Midwives*, 2010, http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ.aspx.
32) NMBA, *Professional Indemnity Insurance Arrangements Registration Standard*, 2012, p 1, http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx.
33) Ibid.
34) Ibid.
35) NMBA, *Guidelines for Professional Indemnity Insurance Arrangements for Midwives*, 2012, p 3, http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx.
36) Anon, 'Punished for looking after the family', *Union News*, 2012, http://www.nswnurses.asn.au/news/37984.html.

37) NMBA, *Recency of Practice Registration Standard*, 2012, p 1, http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx.
38) Ibid.
39) Ibid.
40) NMBA, *Recency of Practice FAQ,* 2010, http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ.aspx.
41) NMBA, *Draft Policy on Re-entry to Practice for Nurses and Midwives*, 2011, http://www.nursingmidwiferyboard.gov.au/News/Past-Consultations.aspx.
42) NMBA, *Endorsement for Scheduled Medicines for Registered Nurses Registration Standard*, 2010, http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx.
43) NMBA, *Registration Standard for Endorsement for Scheduled Medicines for Midwives*, 2011, http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx.
44) There is also provision for endorsement as a midwife practitioner under section 96 of the *National Law*. However, as explained in this chapter, this provision has not been used, as there is only one midwife practitioner currently endorsed in Australia and this person transitioned across from a jurisdictional registration.
45) NMBA, *Endorsement as a Nurse Practitioner Registration Standard*, 2011, http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx.
46) Ibid, p 1.
47) NMBA, *Guidelines on Endorsement as a Nurse Practitioner*, 2011, p 4, http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx.
48) Ibid.
49) Ibid, p 3.
50) NMBA, *Position Statement 27/10/2011 Scope of Practice of Nurse Practitioners*, 2011, http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Position-Statements.aspx.
51) Ibid, p 1.
52) NMBA, *Guidelines on Endorsement as a Nurse Practitioner*, 2011, p 4, http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx.
53) Ibid, p 5.
54) World Health Organisation Europe, *European Union Standards for Nursing and Midwifery: Information for Accession Countries*, 2nd ed, 2009, www.euro.who.int/__data/assets/pdf_file/0005/.../E92852.pdf.
55) Rosskam E, Pariyo G, Hounton S and Aiga H, *The State of the World's Midwifery 2011: Midwifery Workforce Management and Innovation*, 2011, p 8, http://www.who.int/entity/workforcealliance/media/Alliance_backgrd_SWMR.pdf.
56) NMBA, *Recency of Practice FAQ*, 2010, p 1, http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ.aspx.
57) NMBA, *Registration Standard for Eligible Midwives*, 2010, http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx.
58) NMBA, *Registration Standard for Endorsement for Scheduled Medicines for Midwives*, 2011, http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx.
59) Australian College of Midwives Inc., *ACMI Position Statement: Midwifery and the Nurse Practitioner Project*, ACMI, Canberra, 2005.
60) Commonwealth Department of Health and Ageing, *Maternity Services Review: Overview*, 2008, http://www.health.gov.au/internet/main/publishing.nsf/Content/maternityservicesreview.
61) NMBA, *Registration Standard for Eligible Midwives*, 2010, http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx.
62) Ibid, p 1.
63) NMBA, *Guidelines and Assessment Framework for Registration Standard for Eligible Midwives and Endorsement for Scheduled Medicines*, 2010, p 11, http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx.
64) NMBA, *Registration Standard for Eligible Midwives*, 2010, p 1, http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx.
65) Ibid.
66) Ibid.
67) Ibid.
68) *Health Practitioner Regulation National Law Act 2009* (Qld), Schedule, Part 7, s 129.
69) NMBA, *Guidelines for Professional Indemnity Insurance Arrangements for Midwives*, 2012,

p 3, http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx.

70) Ibid, p 6.

71) Commonwealth Department of Health and Ageing, *Maternity Services Review, Questions and Answers: Midwife Professional Indemnity*, 2010, http://www.health.gov.au/internet/main/publishing.nsf/Content/Maternity+Services+Review-Q&A-PIMI.

72) NMBA, *Guidelines for Professional Indemnity Insurance Arrangements for Midwives*, 2012, p 6, http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx.

73) NMBA, *Safety and Quality Framework*, undated, http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx.

74) Ibid, p 1.

75) Ibid, pp 3–4.

76) Ibid, p 2.

77) NMBA, *Codes, Guidelines and Statements: Codes and Guidelines*, http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx.

78) Ibid.

79) NMBA, *Codes, Guidelines and Statements: Position Statements*, http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Position-Statements.aspx.

80) NMBA, *Codes, Guidelines and Statements: FAQ and Fact Sheets*, http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ.aspx.

81) AHPRA, *Notifications and Outcomes: Conduct, Health and Performance*, 2012, http://www.ahpra.gov.au/Notifications-and-Outcomes/Conduct-Health-and-Performance/Performance.aspx.

82) AHPRA, *Notifications and Outcomes: Notification Process*, 2012, http://www.ahpra.gov.au/Notifications-and-Outcomes/Notification-Process.aspx.

83) Ibid.

84) Health Professionals Council Authority, *Frequently Asked Questions*, 2012, http://www.hpca.nsw.gov.au/Frequently-Asked-Questions/default.aspx.

85) Australian Nursing and Midwifery Accreditation Council, *About ANMAC*, 2012, http://www.anmc.org.au/accreditation.

This page intentionally left blank

Chapter 9

Coronial jurisdiction

If a nurse or midwife is to become caught up in any aspect of the legal system, the Coroner's Court is the most likely place for that to occur. In turn, the outcome of a coronial inquest may have significant professional implications for the nurse or midwife — the findings of a coronial inquest may be the springboard for a person or party to commence civil or criminal proceedings involving the nurse or midwife. For those reasons, a knowledge and understanding of the coronial jurisdiction is important to all practising nurses and midwives.

The position of coroner in our legal system

Coroners have been in existence for many hundreds of years and their presence in our legal system is part of the legacy we inherited from the English common-law system.

All of the states and territories have legislation dealing with the role and function of coroners and for once the title of the Act is the same in each state and territory — that is, the *Coroners Act.*[1]

The primary role of a coroner is to detect unlawful homicide; that is, when a person dies in unusual, unexpected, violent or unnatural circumstances, it is necessary to inquire into the manner and cause of death to ensure that no 'foul play' goes undetected.

The coronial court structure varies a little from state to state and territory to territory, generally depending on the size and coronial workload of the jurisdiction. All states appoint a person to the position of State Coroner, and territories appoint a Territory Coroner. In all jurisdictions, except Victoria, the person appointed as State or Territory Coroner is a magistrate. In Victoria, the person appointed is a County Court Judge. The State or Territory Coroner is responsible for overseeing and coordinating the coronial services of the state or territory. In carrying out their coronial functions and as the workload demands it, the State or Territory Coroner is assisted by additional magistrates appointed as coroners, either on a full-time or an as-required basis.

In the capital cities in the larger states, Coroners' Courts are usually separate courts because of the volume of work they are required to perform. Where that is not the case, particularly in regional cities and country towns, the local court house is used as the venue for coroners' inquests.

In an inquest the coroner is assisted by a lawyer generally referred to as 'counsel assisting the coroner'. The task of that person, with the assistance of the police officers who have investigated the death of the person concerned, is to produce evidence, including calling witnesses considered relevant, to enable the coroner to determine those matters that he or she is required to establish.

The role of the coroner

The primary task of the coroner is to establish the following facts:

- that death occurred;
- the identity of the deceased;
- the date, place, manner and cause of death;

and, where relevant,

- the cause of fires or explosions.

Reportable deaths leading to an inquest

Obviously, a coronial inquest is not required into the death of every person. For the coroner to have the power to investigate a person's death, the death must be a 'reportable death' as defined by the *Coroners Act* of the state or territory. The police usually notify the coroner of such a death, once the death is reported to them.

What constitutes a 'reportable death' varies from state to state and territory to territory. Although the following is not exhaustive, in general terms, a death must be reported to a coroner in the following circumstances:

- where the person died unexpectedly and the cause of death is unknown;
- where the person died in a violent or unnatural manner;
- where the person died during the process or as a result of being administered an anaesthetic;
- where the person was 'held in care' or in custody immediately before they died;
- where a doctor has been unable to sign a death certificate giving the cause of death; or
- where the identity of the person who has died is not known.

In relation to the death of a person in a hospital or healthcare setting, the obligation to report such a death to a coroner will depend on the circumstances of the death. Each state and territory provides for such circumstances but in slightly different wording.

In New South Wales, section 6, amongst other provisions, says that a person's death is reportable 'where the person's death was not the reasonably expected

outcome of a health-related procedure carried out in relation to the person'. A 'health-related procedure' is defined as 'a medical, surgical, dental or other health-related procedure (including the administration of an anaesthetic, sedative or other drug)'.

In Victoria, section 4 refers to a death that occurs 'during a medical procedure' and where 'a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death'. A similar provision is to be found in section 10AA of the Queensland Act, although expressed in more detail and wider terms.

The Northern Territory (s 12), Tasmania (s 3) and Western Australia (s 3) all refer to a death that occurs 'during an anaesthetic' or 'occurs as a result of an anesthetic and is not due to natural causes'.

The Australian Capital Territory Act does not define 'reportable death' but section 13 requires that a coroner 'must' hold an inquest into the manner and cause of a person's death where (amongst other provisions) the person 'dies during or within 72 hours after, or as a result of an operation of a medical, surgical, dental or like nature or an invasive medical or diagnostic procedure'.

All states and territories require a death to be reported where the person dies while in police custody or control, or while in gaol, where the person is being cared for within the relevant mental health provisions of the state or territory, or where the person is a child or young person in care.

Who notifies a 'reportable death'

In a hospital or healthcare-related environment where a person's death is 'reportable', the relevant hospital or healthcare authority notifies the local police station who, in turn, submits the notification of that death to the Coroner's Office. If a person died in a hospital or nursing home in circumstances that would render that death 'reportable' and the authorities failed to notify the police, a member of staff or a relative of the deceased could report that death to the police. The police would then investigate that report and notify the coroner if satisifed it was a 'reportable death'. All states and territories make provision that 'any person who has reasonable grounds to believe that a reportable death has not been reported' must report it to a police officer or coroner as soon as possible. A failure to do so is considered an offence subject to financial penalty and, in the case of the Australian Capital Territory and South Australia, potential imprisonment.[2]

The procedure following notification of a 'reportable death'

Once a death has been reported to police, the coroner will receive a report submitted by the police detailing their investigation into the person's death together with any accompanying statements. As well, an autopsy may be undertaken. That material together with additional scientific forensic tests such as toxicology results, will be considered by the coroner to determine whether a coronial inquest need be held or whether the coroner is able to make the formal findings as to the person's death without the need to call witnesses and receive further evidence. The latter course of action, that is, to dispense with an inquest, is open to a coroner who will formally

certify the death of the person and the findings made in chambers. However, in a hospital, nursing home or healthcare setting, such an approach is unlikely and the coroner will proceed to a formal coronial inquest.

A coroner is generally somewhat cautious in deciding to dispense with an inquest arising out of a patient's death in a hospital or healthcare-related environment, even if there are no suspicious circumstances. The main reason for such caution is that, on many occasions, the relatives of the deceased want to know what happened, particularly if the person's death was unexpected and not directly attributable to whatever had necessitated the patient's being in hospital. In such a situation it is always desirable to have an inquest so that the relatives of the deceased have the opportunity to discover the facts that led to the patient's death and to reassure themselves that all that could have been done was done.

It is important to bear in mind that the coroner may come to the view that the person died as a result of a criminal act committed by a known or unknown person. In such circumstances it is not the task of the coroner to formally charge a known person with a criminal offence or determine a person's guilt or innocence. A coroner does not conduct criminal trials. Such proceedings must be undertaken in another court. If a coroner concludes that a person met his or her death as a result of a criminal act, the coroner refers that matter to the prosecuting authorities for their consideration and action. It is possible for criminal charges to be laid against a nurse or midwife following a coroner's inquest. Admittedly it would be relatively rare for such an outcome to occur — but it could happen, and has happened. For example, in New South Wales, in two separate inquiries in 1993 and 1994 respectively, the coroner found that the evidence disclosed that the actions of the nurse concerned were sufficient to warrant the circumstances of each matter being referred to the prosecuting authorities to determine whether criminal charges should be laid. Both cases involved serious medication errors resulting in the death of the patient concerned.

In the first case, a newly graduated registered nurse employed to work in the intensive care unit of a major public teaching hospital in Sydney injected Dylantin oral suspension into the central venous line instead of down the nasogastric tube of a patient in his care.[3] As a result the patient had a cardiac arrest and died. The coroner's inquest that followed determined the circumstances giving rise to the patient's death were such as to amount to criminal negligence and referred the matter to the Director of Public Prosecutions. The nurse was subsequently charged with manslaughter. A jury acquitted the nurse of that charge.

In another incident a registered nurse significantly overdosed a patient with Methotrexate, causing death.[4] This was despite the clearly written instructions in the patient notes as well as evidence given which acknowledged that the dose administered was far in excess of what would reasonably be expected to be given. In this inquiry into the patient's death the coroner found that:

> The breach of the duty of care by certain persons was not merely a breach which called for compensation, but the evidence clearly establishes there has been evidence which amounts to recklessness and gross negligence.[5]

In considering all of the evidence in the matter, as well as the coroner's findings, the prosecuting authorities ultimately decided not to lay any criminal charges against the nurse concerned.

While the coroner may not make any finding that a criminal offence has been committed by a person or persons, he or she may conclude that the care given by hospital or healthcare staff was significantly deficient in a number of areas. Although such a view may emerge from the evidence, the coroner has no power to determine the outcome of potential litigation on behalf of the relatives of the deceased. If the relatives believe that hospital or healthcare staff have been professionally negligent as a result of what was disclosed at the inquest, they must pursue their action in the appropriate civil court depending on the amount of monetary compensation being sought.

If the relatives of the deceased suspect that hospital staff may have been negligent in caring for the deceased leading up to his or her death, they will often use the coroner's inquest as a means of eliciting evidence to enable them to decide whether or not it is worthwhile pursuing an action in negligence in another court.

Findings and recommendations that may arise from a coroner's inquest

At the conclusion of an inquest, in addition to determining the manner and cause of death as required, the coroner may, if he or she so wishes, comment critically about the standard of care given to the deceased in a hospital, nursing home or healthcare setting and make certain recommendations.

The recommendations made are usually directed to the government of the day or the organisation responsible for overseeing the actions which led to the deceased's death. For example, a coroner's inquest was held in Sydney into the death of an elderly patient who had died as a result of burns received from suddenly turning on the hot water tap while showering in hospital. The sudden rush of scalding water so shocked the patient that she was unable to turn the tap off before help arrived and she sustained severe burns from which she later died. In giving his findings as to the manner and cause of death, which was as a result of severe burns sustained while showering, the coroner also made certain recommendations concerning the temperature of hot water in hospitals and nursing homes. He recommended that, in hospitals and nursing homes, the temperature of the hot water should be thermostatically controlled to prevent such occurrences. The coroner's recommendation was forwarded to the appropriate state government department and, as a result, hospitals and nursing homes in New South Wales were directed to ensure that the temperature of hot water provided for patient use was such that sustained exposure would not cause severe burns.

All states and territories have provisions in their respective *Coroners Acts* for a coroner to make recommendations arising from an inquest.[6] New South Wales provides for recommendations to be made concerning 'matters relating to public health or safety'; likewise, the Australian Capital Territory, the Northern Territory, Queensland, Tasmania, Victoria and Western Australia. South Australia provides for recommendations on matters that 'might … prevent or reduce the likelihood of recurrence of a similar event' which would embrace public health or safety issues. Queensland has a similar provision in addition to 'public health or safety'. Both

Queensland and Western Australia provide for a coroner to refer a matter arising from an inquest to a 'disciplinary body of a trade or profession'. Such an express provision clearly refers to the registration authority relating to nurses and midwives. A reference received from a coroner to such an authority would clearly provide the basis for an inquiry to be made pursuant to the disciplinary provisions of the nurse or midwife's registering authority which may lead to a charge of professional misconduct. While the other states and territories do not have the express provision for a coroner to make a reference to 'a disciplinary body of a trade or profession' as do Queensland and Western Australia, it is clear in our view that such a reference can and has been made by a coroner in the other states under the catch-all provision of 'public health or safety'.

The role and powers of nurse and midwife registration authorities in relation to disciplinary proceedings is detailed in Chapter 8. Also highlighted in earlier chapters, particularly relating to professional negligence and the standard of care expected of nurses and midwives in certain clinical situations, are the outcomes of a number of coronial inquests where the coroner has been critical of nursing staff. The facts and circumstances of some of those examples have formed the basis for ongoing civil litigation by the family of the deceased seeking compensation for negligence by the staff concerned.[7]

State and territory health departments have a responsibility to act upon recommendations made by a coroner that are relevant to the administration and delivery of health services in the particular state or territory.

Where a coroner hands down a report identifying the manner and cause of a person's death that includes critical reference to aspects of care given in a hospital or healthcare facility, as well as recommendations intended to be implemented to address the deficiencies identified, that report will be sent to the Attorney-General and/or Minister for Health. As a matter of procedure, upon receipt of a coroner's report and recommendations, the minister responsible is required to act upon the report and recommendations, and advise the State Coroner accordingly within a set time frame — usually between 3 and 6 months. The actions undertaken by the minister may include:

- referring the whole or parts of the matter to others for investigation and report back; for example, to the Chief Health Officer, the body for investigating healthcare complaints, or relevant public health branches;
- upon receipt of the investigatory report, initiating one or more of the following actions:
  - the development of and promulgation of new policy;
  - remedial action or a change of procedure within the healthcare system;
  - professional disciplinary action against identified healthcare professionals.

The relevance of a coroner's inquest for nursing staff

It is important to remember that in all states and territories, evidence given before a coroner's inquest may form the basis of disciplinary charges against a healthcare professional brought by the relevant registration authority, or as a result of a complaint lodged by a relative of the deceased following evidence disclosed at the

inquest. It is for this reason primarily that nurses and midwives should be particularly aware of the power of coroners' inquiries to impact on their professional registration.

As stated earlier, the specific legislative provisions that apply to the holding of inquests are accompanied, in some situations, by the power of the coroner to dispense with an inquest if he or she is satisfied that there are no suspicious circumstances surrounding the death. In relation to hospitals and nursing homes or healthcare-related environments, however, while the coroner may dispense with an inquest, he or she is unlikely to do so because of the questions generally raised by the relatives of the deceased as to the circumstances of the person's death, particularly if it was unexpected.

Legal representation at the inquest

In all states and territories, any person who is required to give evidence at a coroner's inquest is deemed to have 'sufficient interest' in the inquiry to permit them to have legal representation. If staff of a hospital, nursing home or healthcare-related environment are involved in an inquest, the employer will usually ensure that, if necessary, staff involved are represented by their legal representative. If that is not done, or if conflict arises, legal representation is generally provided for nurses or midwives if they are a member of the relevant nursing organisation in each state and territory.[8]

If such legal representation is not provided or available, it may be possible to apply for state-funded legal aid if it is available, or the nurse or midwife may have to obtain and pay for his or her own legal representation. Given the cost of legal services it is to be hoped such a situation never arises.

For those nurses and midwives who are members of the relevant nursing organisation in their state or territory, preliminary advice should be obtained to assist them in the giving of statements for coroners' inquiries and disciplinary inquiries generally. As a preliminary guide, an extract from guidelines prepared by the New South Wales Nurses' Association is of sufficient general application to nurses and midwives in all states and territories as to warrant setting it out at the end of this chapter.[9]

Relevant advice and procedure for nurses and midwives in relation to a coroner's inquest

A coroner's inquest can sometimes be a harrowing experience for healthcare professionals who are unaccustomed to court procedures and often feel they are being put on trial.

Given the potential for civil liability or criminal charges to arise from a coroner's inquest, a nurse or midwife who is to be called to give evidence at an inquest should be fully aware of their rights and obligations in relation to such hearings. In the first instance, they should be aware of their right to refuse to answer any questions from a police officer or others in authority which may tend to give rise to a criminal charge against them; that is, incriminate them. All members of the community have this right. While such an outcome to a coroner's inquest for nursing staff is rare, it is important to remember that right and, as a general rule, make no statement, written or otherwise, until legal advice is obtained.

In some cases, the first inkling that a nurse or midwife will have that they are required to give evidence at an inquest is when they are approached by a police officer requesting a statement as to their recollection of events at the time of the patient's death — sometimes many months after the death occurred. The fact that a police officer requests a statement in such a situation does not mean that a criminal offence is suspected. It is just that one of the routine tasks of police officers is to obtain the necessary statements for the coroner which they, in turn, refer to the coroner for his or her consideration once their inquiries are completed.

When a request for a statement is made by a police officer, it is advisable to indicate that you will agree to assist with whatever relevant information can be clearly recalled that may assist the coroner in his or her inquiry as to the manner and cause of death. A refusal to cooperate or appear at the inquest will normally result in the issue of a subpoena compelling attendance. However, it is wise, even as a precautionary measure, to seek legal advice concerning any statement to be made or provided to the police if the events surrounding the patient's death are such as to give rise to any concern being expressed.

It is perfectly proper and legally permissible to decline to give any statement immediately but to indicate a willingness to do so after legal advice has been obtained. The guiding principle in this respect should always be that, if in any doubt, seek advice. With hindsight, it may prove to have been unnecessary, but it is better to err on the side of abundant caution in such situations.

PROCEDURE PRIOR TO AN INQUEST

As referred to earlier, when a reportable death occurs, it is necessary to notify the police. That notification will usually be undertaken by management. However, there may be occasions in small or isolated rural hospitals and healthcare services, or nursing homes, where the registered nurse or midwife may have to notify the local police. It is expected that a clear protocol would be in place as to who is responsible for notifying, but in circumstances where this is unclear, inquiries should be made of the hospital or healthcare service management in the first instance. However, if, given the circumstances, that is not possible, the medical officer certifying the death or otherwise, or the registered nurse or midwife present at the time, may have to notify the local police.

While it is most unlikely to arise, a registered nurse or midwife, in circumstances where he or she believes the person has died under suspicious or unusual circumstances and that the manner and cause of death has not been correctly recorded, is under a legal obligation to report the death to the local police. Should such a situation arise, the nurse or midwife should, in the first instance, raise his or her concerns with the medical officer involved in certifying the death.

If notification is made independently of the healthcare authority and/or medical officer concerned, it is advisable that the nurse or midwife be able to objectively detail the facts and circumstances relied upon to notify the police.

When an inquest is held or likely to be held

Nursing and midwifery staff should be generally mindful of situations where the death of a patient may give rise to a coroner's inquest. As a matter of policy, where

possible, staff should be informed by administration or the patient's doctor if an inquest is likely to arise following a patient's death. If that is done it will allow the nursing staff involved to obtain legal advice as necessary and prepare a draft statement at the time of the patient's death rather than relying on their memory many months after the event. With some inquests, staff have been asked for statements up to 4 years after the patient's death when they generally, and not surprisingly, have little or no recollection of the patient, let alone the events surrounding the patient's death.

At the time of notification the police will usually take the minor preliminary details and return some time later for any statements that may be required. In some situations the police prefer to make their inquiries immediately after they are notified and proceed to question staff on the spot. That situation often occurs in psychiatric hospitals or institutions, where it is compulsory under the *Coroners Act* for the coroner to be notified of the death of every patient. More often than not the patients who die in psychiatric hospitals, particularly the elderly psychogeriatric patients, die from old age and natural causes with no suggestion of suspicious circumstances or negligent treatment on the part of nursing staff. However, because the police must take statements, they will normally do so at the time of death, in order to have the matter dealt with as quickly as possible and without further inconvenience to the nursing staff concerned. In this situation, it is sensible to give the police whatever information is required at the time. However, if there are concerns regarding the circumstances surrounding the patient's death, arrangements can be made to give a statement at a later time after legal advice has been obtained. In the circumstances outlined, particularly concerning inquests into the death of patients in psychiatric hospitals, the coroner may dispense with the need for a formal inquest once the statements from the police have been received.

The body should be left as it is at the time of death. All drainage tubes, intravenous lines, in-dwelling catheters, nasogastric tubes, cardiac monitoring pads, sutures, dressings and so forth should remain in position. Obviously some of those lines will have to be disconnected externally and capped or sealed. The body should then be transported to the morgue in the normal manner and in due course arrangements will be made for a post-mortem to be conducted.

If it appears that a patient or client's death is reportable and that a statement will be required, a draft statement or notes should be prepared by the nurse or midwife setting out the relevant details as soon as possible, while the relevant events are fresh in the memory. This nurse should retain such notes until a formal statement is called for. A draft statement or notes should not be handed over to the police or relevant authorities until any necessary legal advice is obtained and a formal statement prepared. When a formal statement is requested by the police or hospital administration, the draft statement or notes made at the time of the patient's death will assist in writing such a statement. Once again, should any particular concern be felt or expressed, it is advisable that legal advice be sought before submitting the formal statement. When a statement is to be given to the police or healthcare service administration, a copy should always be retained.

Occasionally, a statement is requested some considerable time after the event when, in most cases, the particular patient has long been forgotten, and no draft

statement or notes were made at the time of death. In such a case, it may be necessary to request to peruse the patient or client notes to refresh one's memory. That does not always help recall specific details, but it does allow identification of one's handwriting of any entries made at the time.

In an inquest into the death of a person who has been a patient or client of a hospital or healthcare service and who has died in circumstances related to the person's care or treatment received, his or her medical and care records will be very carefully scrutinised to ascertain if there is any information contained within them that may assist the coroner to determine the manner and cause of death. If the person's relatives are legally represented at the inquest, they will also have access to those records and may wish to cross-examine the medical and nursing staff about entries made.

Accordingly, it is important for nurses and midwives to ensure entries made in patient or client records are relevant, contemporaneous and objectively factual. Refer to Chapter 7 on report writing for assistance in such matters.

Extract from the New South Wales Nurses' Association guidelines for the purposes of giving statements for coroners' inquests and other disciplinary matters

The Association has formulated a number of guidelines which it recommends to members faced with the prospect of an interview in relation to any of the above situations described as a 'disciplinary/fact-finding interview' by any investigating body or officer. They are as follows:

1) Contact the Association for advice. To obtain the necessary advice you should find out details of the matter in which you are involved, the name and contact number of the investigator and the proposed date and time of the interview or the date for submission of the statement.
2) The Association will contact the investigator on your behalf and seek full particulars.
3) Following this, you should be given at least 24 hours' notice of the time, date and place of the proposed interview. You should not attend any interview until advised by the Association.
4) You have a right to access a health record of a client relating to a request for an interview or statement, before you provide a statement or attend an interview, to refresh your memory.
5) Members attending interviews may be accompanied by an Association representative who has knowledge of the issues and rights of the member.
6) Prior to attending any interview, you should be advised by the interviewer that:
   a) anything you may say and the transcript of the interview may be used in evidence in any subsequent legal or disciplinary proceedings;
   b) you have the right to either allow or refuse audio or video taping of the interview; and
   c) you may be asked to provide a written statement subsequent to the interview. However, you cannot be made to provide this written statement.

7) If in the course of any interview, matters are raised which go beyond those previously disclosed to you, the interview should be adjourned or concluded so that you can obtain full particulars of the new issue(s) and gain further advice.
8) You should be aware that the interviewer is not permitted to use intimidatory or accusatory terms. If this approach is adopted, the interview should be terminated immediately.
9) Persons conducting the interview should be totally impartial.
10) You should be provided with a copy of the tape and transcript of the interview as soon as practicable after its completion. You should not sign any transcript or record of interview unless you have read it and are satisfied that it is true and correct in every respect.
11) The Association maintains that its members are entitled to a fair, proper and prompt outcome of such investigations and attempts to assist its members to achieve this end.

QUICK QUIZ

Having studied the text in relation to coronial jurisdiction, students should be able to answer the following questions:

1) What is the role and purpose of the Coroner's Court?
2) Is it the same in all states and territories?
3) Under what circumstances is a death examinable by a coroner?
4) Does there always have to be an inquest or can it be dispensed with?
5) If the coroner makes a decision not to hold an inquest, what happens next?
6) How does a Coroner's Court become relevant for nursing staff?
7) If a death has occurred at work that fits within the provisions of the relevant *Coroners Act* what is required to be done? Can the nurse notify the police independently if he or she believes the circumstances warrant it?
8) Who is responsible for notifying police in the event of a death involving the Coroner's Office?
9) If there is a police investigation, what happens?
10) If a nurse or midwife is asked to provide a statement to the police, should he or she agree or may he or she refuse?
11) What do the police do once they collect statements?
12) Are relatives able to request an inquest if they are unhappy with the circumstances in which their relative dies?
13) If an inquest is held, will the nursing staff who have made a statement be required to attend and give evidence?
14) Would a nurse or midwife be entitled to legal representation at an inquest? Who else is entitled to be represented?
15) How important are the patient's records at an inquest? Will the entries made by nursing staff be scrutinised?
16) Apart from determining the manner and cause of death, what else may be the outcome of a coronial inquest?

Endnotes

1) *Coroners Act 1997* (ACT); *Coroners Act 2009* (NSW); *Coroners Act* (NT); *Coroners Act 2003* (Qld); *Coroners Act 2003* (SA); *Coroners Act 1995* (Tas); *Coroners Act 2008* (Vic); *Coroners Act 1996* (WA).
2) *Coroners Act 1997* (ACT) s 77; *Coroners Act 2009* (NSW) s 35; *Coroners Act* (NT) s 12; *Coroners Act 2003* (Qld) s 7; *Coroners Act 2003* (SA) s 28; *Coroners Act 1995* (Tas) s 19; *Coroners Act 2008* (Vic) ss 10 and 12; *Coroners Act 1996* (WA) s 17.
3) Coroner's Inquest into the death of Clinton Norwood, Westmead Coroner's Court, February 1994.
4) Coroner's Inquest into the death of Sara Slapp, Westmead Coroner's Court, July 1993.
5) Ibid.
6) *Coroners Act 1997* (ACT) s 57; *Coroners Act 2009* (NSW) s 82; *Coroners Act* (NT) ss 27 and 35; *Coroners Act 2003* (Qld) ss 46 and 48; *Coroners Act 2003* (SA) s 25; *Coroners Act 1995* (Tas) s 30; *Coroners Act 2008* (Vic) s 72; *Coroners Act 1996* (WA) ss 25 and 50.
7) See Chapter 3: Coroner's Inquest into the death of Samara Lea Hoy, Southport Coroner's Court, Feb–Jun 2010; Coroner's Inquest into the death of Tracey Baxter, NSW Coroner's Court, 1979; *McCabe v Auburn District Hospital* (SC (NSW), Grove J, No. 11551 of 1982, 12 May 1989, unreported).
8) The New South Wales Nurses' Association; the Queensland Nurses' Union; and in all other states and territories, the branch of the Australian Nursing Federation.
9) The full text of the guidelines can be found on the Nurses' Association website in the members-only information section: www.nswnurses.asn.au.

Chapter 10

Human tissue transplantation

History and background of human tissue transplantation and research

Human tissue transplantation has been a growing part of medical and scientific development for many years. In his book *The Body as Property*, Russell Scott recounts that more than 2000 years ago Indian surgeons were transplanting human skin in the operation of rhinoplasty.[1] Blood transfusions have long been commonplace and the nineteenth century saw the first transplantation of certain body parts, such as teeth and bone. The twentieth century and more particularly the last 30 to 40 years have seen enormous developments in the field of human tissue transplantation. The first successful kidney transplant was performed in 1954 and the first successful transplant of a human heart took place in December 1967, in South Africa; but on that first occasion the recipient died 18 days later. However, a heart transplant performed in the United States only 10 months later kept the recipient alive for over 8 years.[2] Since that time the list of tissue, regenerative and non-regenerative, and even human and non-human, that has been transplanted with varying degrees of success has grown considerably. Herring has provided a useful list of the different types of organ transplantation currently available or being explored, and this is set out in Box 10.1.

At the time of writing, the use of human tissue for transplantation, research and other purposes in Australia is the subject of considerable controversy, discussion and debate. A total of 337 Australians who died in 2011 donated their organs, benefiting 1001 people in need of a transplant, figures released in December 2011 show. The number of donors was 28 more than for 2010, which translated into an additional 70 recipients, the highest annual total of deceased organ donors and transplant recipients in Australia's history. However, Australia's per capita donor rate remains one of the poorest among developed nations. Transplant advocacy group ShareLife says Australians in need of an organ transplant will still wait longer than patients in 23 other countries, including Argentina, Uruguay and Puerto Rico. The Parliamentary Secretary for Health, Catherine King, said the 2011 figures were encouraging but the international comparisons were sobering. 'We're continuing to

BOX 10.1
TYPES OF ORGANS POTENTIALLY AVAILABLE FOR TRANSPLANTATION[3]

1) **Live organ donation:** an organ is taken from a living person and given to another. Clearly, this kind of organ donation is limited; one that is possible is the kidney.
2) **Cadaver organ donation:** an organ is taken from a person shortly after death and transplanted into another.
3) **Xenotransplantation:** an organ is taken from an animal and used in a human.
4) **Genetically created organs:** scientists are currently working on this technology. The hope is that at some point an organ can be created in a laboratory from human genetic material that can then be placed into a person.
5) **Artificial organs:** some work is being done to create robotic/mechanical organs for transplant, with some success.

see the rate of organ donation in Australia go up. We're now at 14.9 donors per million population and that's up just over 11 from two years ago,' she told reporters at Melbourne's Western Hospital. '(But) there is a long way to go before our rates of organ donation are comparable with other countries.'[4]

Much of this debate is beyond the scope of an undergraduate textbook and some aspects of the debate, particularly those relating to the use of human genetic material in research, will only be mentioned briefly, with further references supplied for the interested reader. Some of the controversy relates to the retention and use of human tissue after death and the conduct of post-mortem examinations, another topic not directly related to the regular work of nurses or midwives. However, this latter subject has been a matter of such concern among the general public, it will be discussed in some detail as nurses (and sometimes midwives) may find themselves required to answer questions by anxious patients and (more probably) relatives. As a matter of careful practice, specific questions about any matter relating to the use of human tissue should be referred to the appropriate treating medical practitioner, but this area of law has developed so rapidly that undergraduate nurses and midwives now do need to be aware of it.

Another area where the law has developed rapidly in recent years is the development of assisted reproductive technologies, and a short section will be included on the legal provisions in this area.

Classifications of human tissue

Human tissue is classified in two ways for the legal consideration of its use in transplantation: namely, regenerative and non-regenerative tissue. Regenerative tissue is the tissue that can be replaced in the body by the normal process of growth and repair. Non-regenerative tissue is all other tissue. The list in Table 10.1 provides an example of the wide range of regenerative and non-regenerative tissue currently being transplanted in one form or another.

Table 10.1
Classification of tissue for transplant purposes

Regenerative tissue	Non-regenerative tissue
blood	blood vessels
bone marrow	bone and cartilage
skin	corneas
semen	ear tissue (ossicles, tympanic membrane)
	fascia
	heart
	hormone-producing glands (pituitary, thyroid etc)
	intestines
	kidneys
	liver
	lung
	pancreatic tissue

Development of law in relation to usage of human tissue

The subject of human tissue transplantation inevitably gives rise to legal and ethical issues. As is often the case, the law has been slow to respond to these issues. In addition, the established common-law principles are clearly inadequate when trying to cope with the complexities of the issues involved. Common-law principles have for many years recognised only a limited right to deal with a person's body after death — usually only for the purposes of burial. Legislation in relation to the functions of the coroner clearly established the right to conduct post-mortems, and permission to do so could also be given by the surviving spouse or relative. Common-law limitations also prohibited the use of dead bodies and the retention of body organs for the teaching of anatomy and research purposes. Accordingly, it was necessary for parliaments to allow such procedures by passing the appropriate legislation, known as the *Anatomy Act* in most states and territories.

The common law has also never permitted the removal of body parts or organs from a living person. Such a principle rested largely on the belief that the removal of a body part or organ from a living person, even with the person's consent, was not of benefit to that person and technically constituted the criminal offence of maim. In addition, the increasing amount of tissue transplantation, particularly kidney transplants, highlighted the fact that the state of the law was not sufficient to deal with the legal problems that arose. Those problems included the issue of consent generally, the removal of tissue from living persons and the need to make specific provisions concerning children.

The need for parliaments to legislate in this area was first recognised in Australia in 1976, when the then Commonwealth Attorney-General, Mr R J Ellicott, referred the whole matter of human tissue transplantation to the Australian Law Reform Commission under wide-ranging terms of reference. The commission produced its report in 1977, entitled *Human Tissue Transplants*.[5] One of the main features of the report was the proposed draft legislation, which was set out in Appendix 4 to the report. It was intended that the draft legislation, presented to the Commonwealth Government in 1977, would be used as a model by all of the Australian

states and territories in relation to this subject. The subject of tissue transplantation is an area within which the states and territories have power to legislate and hence the Commonwealth Government could not impose the draft legislation on the states or territories — it could only put it forward as a suggested model. The Commonwealth Government used the draft legislation proposed by the Australian Law Reform Commission as the basis for the *Transplantation and Anatomy Act 1978* in the Australian Capital Territory.

Following the lead of the Commonwealth Government in the Australian Capital Territory, all states and territories have now introduced legislation based on the Commonwealth's proposed draft legislation.[6] The legislation deals with such matters as:

- the donation of tissue by living persons, particularly with reference to children and the issue of consent (blood donations are dealt with separately);
- the donation of tissue after death;
- the donation of tissue for anatomical purposes;
- issues arising in relation to post-mortem examinations;
- a prohibition of trading in tissue;
- a definition of death.

The even more complex legal issues arising from in-vitro fertilisation and embryo transplants are not dealt with in the legislation and have required further legislation by most jurisdictions in recent years. This is discussed further later in this chapter.

The legislation varies to some extent between the states and territories, but in this area there is a significant degree of commonality between them, largely because they have adopted the draft legislation of the Australian Law Reform Commission. This particular piece of legislation is of importance to all hospitals and healthcare personnel. It is of greatest significance to nursing and medical staff in intensive care and other such units because the majority of organs for transplantation still tend to come from patients who die from severe trauma, particularly as a result of motor vehicle accidents, although donation after cardiac death is increasing.[7]

Each of the states and territories has adopted the parts or sections of the proposed draft legislation that they have considered relevant or necessary for their purposes; not all matters mentioned above have been dealt with, however. As an example, South Australia and Western Australia have not adopted the definition of death as proposed, and hence reference to that will not be found in their respective Acts. Also, New South Wales makes no reference to donations for anatomical purposes or schools of anatomy, as such matters are covered in the New South Wales *Anatomy Act 1977*.

Imogen Goold makes the observation that:

> In Australia, human tissue use is regulated by a piecemeal, sometimes conflicting body of legislation and case law. In general, these laws have been developed to deal with specific uses of tissue, such as the *Human Tissue Acts*,

> and hence do not form a body of rules that can be easily extrapolated to the emerging uses of tissue. The acts are limited in scope and deal only with consent to the removal of tissue, not with its subsequent uses. They also only cover the removal of tissue for transplantation, medical and research purposes, which are rapidly becoming only a few of the many uses to which human tissue may now be put.[8]

The provisions of the various statutes are set out in Table 10.2 and are discussed below.

The requirement for consent in live donations

In situations where tissue is to be donated from a live donor the requirement for valid consent is critical, as donating tissue carries with it a degree of risk due to the need to obtain the tissue from a live individual. However, this risk becomes even more significant if the tissue removed will not regenerate. The requirements for consent to removal of non-regenerative tissue for donation are quite rigorous, and understandably so, particularly where children are concerned. In 2007 the National Health and Medical Research Council (NHMRC) endorsed the guidelines entitled *Organ and Tissue Donation by Living Donors: Guidelines for Ethical Practice for Health Professionals*.[9] The document points out that, at the time of writing, in Australia, 40 percent of kidney donations were from living donors. This figure is likely to be higher now.

The guidelines themselves embody a set of principles, which are a valuable guide to healthcare professionals in terms of addressing the issues and concerns of living donors, and these are set out in Box 10.2.

For nurses and midwives who are interested in this topic the NHMRC website (www.nhmrc.gov.au) also contains excellent advice for people in the community who are contemplating donation. The booklet, *Making a Decision about Living Organ and Tissue Donation*[10] also identified a set of principles for the benefit of the public. They are as follows:

- **Living donation must be altruistic**

  Altruism means that the donor is thinking only about the other person and is not expecting to receive rewards.
- **The decision to donate must be free and voluntary**

  People should not be forced or influenced by emotional pressures or promises of rewards like money.
- **Both donors and recipients must be fully informed**

  Donors and recipients need clear information so that they can understand what the risks are and what might happen in the future.
- **Everyone involved in the decision-making process must be treated with respect and care**

  Whether a donation goes ahead or not, the donor assessment and transplant teams follow the ethical principles outlined in this booklet and work towards the best possible results for the donor and recipient.

Table 10.2
State and territory provisions for blood and tissue donation

State/territory legislation	Tissue donation by live adults	Tissue donation by live children	Blood donations	Donation of tissue after death	Tissue donation for anatomical purposes	Post-mortem examination	Trading in tissue	Definition of death
Transplantation and Anatomy Act 1978 (ACT)	Section 8 regenerative tissue; section 9 non-regenerative tissue	Section 12 c/f parent and guardian; section 13 regenerative tissue — only to family or relative; section 14 non-regenerative — many restrictions	Section 20 adults; section 21 children	Sections 27–31	Sections 36–41	Sections 32–35	Prohibited under section 44	Section 45
Human Tissue Act 1983 (NSW)	Section 7 regenerative tissue; section 8 non-regenerative tissue	Section 10 regenerative tissue only and only to parent, brother or sister (many requirements)	Section 19 adults; section 20 children	Sections 23–27	See provisions of *Anatomy Act 1977* (NSW)	Sections 28–31D	Prohibited under section 32	Section 33
Transplantation and Anatomy Act 2011 (NT)	Section 8 regenerative and non-regenerative tissue	No provision for children	Section 14 adults; no provision for children	Sections 18–22	Sections 22A–22D	Section 20 coronial consent to removal of tissue; sections 19–23 of *Coroners Act* (NT) coronial consent to autopsy	Prohibited under sections 22E–22F	Section 23
Transplantation and Anatomy Act 1979 (Qld)	Section 10 regenerative tissue; section 11 non-regenerative tissue	Sections 12B–12E regenerative only	Section 17 adults; section 18 children	Sections 22–25	Sections 31–38	Sections 26–30	Prohibited under sections 40–42	Section 45

Transplantation and Anatomy Act 1983 (SA)	Section 9 regenerative tissue; section 10 non-regenerative tissue	Section 12 general prohibition; section 13 only for regenerative tissue	Section 18 adults; section 19 children	Sections 21–24	Sections 29–34	Sections 25–28	Prohibited under section 35	Not defined
Human Tissue Act 1985 (Tas)	Section 7 regenerative tissue; section 8 non-regenerative tissue	Section 12 regenerative tissue only	Section 18 adults; section 19 children	Sections 21–24	Sections 20–34	Sections 25–28	Prohibited under section 35	Section 27A
Human Tissue Act 1982 (Vic)	Section 7 regenerative tissue; section 8 non-regenerative tissue	Section 14 non-regenerative tissue expressly prohibited; section 15 regenerative tissue only	Section 21 adults; section 22 children	Sections 23–26	Sections 32–37	Sections 26A–26D non-coronial autopsy; sections 27–29 of *Coroners Act 1985* (Vic)	Prohibited under section 27	Section 41
Human Tissue and Transplant Act 1982 (WA)	Section 8 regenerative tissue; section 9 non-regenerative tissue	Section 12 general prohibition; section 13 regenerative tissue only allowed for family members	Section 18 adults; section 19 children	Sections 22–24	*Anatomy Act 1930* (WA)	Sections 25–28	Prohibited under sections 29–30	Not defined

BOX 10.2[10]
PRINCIPLES IN THE NHMRC GUIDELINES, ORGAN AND TISSUE DONATION BY LIVING DONORS: GUIDELINES FOR ETHICAL PRACTICE FOR HEALTH PROFESSIONALS

a) Whether the donor and recipient are related or unrelated, living organ and tissue donation is an act of altruism and human solidarity that potentially benefits those in medical need and ultimately society as a whole.

b) Respect for all those involved should be demonstrated through:
   i) decision-making processes that ensure that both donors and recipients are fully informed about potential risks and about alternatives to transplantation;
   ii) ensuring that decisions about donation are free of coercion of any kind including undue emotional pressures or any material incentives such as money or in-kind rewards.

c) In assessing whether to proceed with donation, the autonomy and welfare of the donor take precedence over the needs of the recipient to receive an organ or tissue.

d) Living donation should take place only when there are minimal risks of short and long-term harm to the donor, with no clinically significant loss of a bodily function, and a high likelihood of a successful outcome for the recipient.

e) For those who cannot make informed decisions (for example young children or other dependent persons) to be considered as potential living donors there must be: minimal risks to the donor; no alternative donors available; and the prospective recipient must be a close relative of the child or dependent adult. There must be an independent judgement that the donation is in the overall best interests of the potential donor.

f) Conflicts of interest should be minimised through the use of independent and separate assessment, advice and advocacy for potential donors.[11]

- **Cultural issues must be considered in planning programs and working with families**

  Translators are important to give information to people whose first language is not English. The health professionals involved need to understand and be sensitive to the ways in which culture and beliefs can influence decisions about donation.[12]

ADULTS

The requirement to obtain consent for the removal of regenerative tissue is similar for all statutes, but the extent of detail differs. For example, in the *Transplantation and Anatomy Act 1978* (ACT), section 8 merely states that:

> A person may give his or her written consent to the removal from his or her body of specified regenerative tissue (other than blood) —
>
> a) for the purpose of the transplantation of the tissue to the body of another living person; or
>
> b) for use for other therapeutic purposes or for medical or scientific purposes.

In contrast section 9 of the *Transplantation and Anatomy Act 1983* (SA) has quite detailed provisions, stating that:

> 1) A person who—
>
> a) is not a child; and
>
> b) in the light of medical advice furnished to him understands the nature and effect of the removal,
>
> may, by writing signed by him otherwise than in the presence of any members of his family, consent to the removal from his body of regenerative tissue, other than blood, specified in the consent—
>
> c) for the purpose of the transplantation of the tissue to the body of another living person; or
>
> d) for use for other therapeutic purposes or for medical or scientific purposes.
>
> 2) A person who has given a consent referred to in subsection (1) may, at any time before the removal of the regenerative tissue to which the consent applies, revoke, either orally or in writing, his consent to the removal.

Whilst not every statute specifies the need for the nature and effect of the removal to be explained to the person, as has been discussed in Chapter 4, those requirements are part of the common law in relation to consent to treatment. All statutes require the consent to be in writing.

Under all statutes there is a further requirement for a 24-hour 'cooling-off period' before any non-regenerative tissue can be donated and a specification that the time of consent shall be recorded. Some statutes also offer the option of a medical practitioner issuing a certificate in relation to consent; for example, section 10 of the *Transplantation and Anatomy Act 1978* (ACT).

CHILDREN

Obviously removal of tissue from children carries additional complex ethical problems, particularly because the children are not legally able to make the decision, which means that someone else has to do so on their behalf. Living donation of regenerative tissue from children is only permitted in strict circumstances, and living donation of non-regenerative tissue is only permitted in the Australian Capital Territory and then under the most stringent circumstances, as discussed below.

The National Health and Medical Research Council (NHMRC) guidelines entitled *Organ and Tissue Donation by Living Donors: Guidelines for Ethical Practice for Health Professionals* contains unequivocal advice for ethical decision-making on behalf of children and dependent adults, which is set out in Box 10.3.

Probably as a result of the ethical complexity of this issue, the requirements for children differ considerably between jurisdictions. Some statutes make a clear distinction between parents and guardians for the purposes of giving consent within the legislation; for example, section 12 of the *Transplantation and Anatomy Act 1978* (ACT). Most statutes limit the possible recipients of regenerative tissue from children to a range of family members — family members or relatives of the child, unspecified (ACT, Tas, WA); brothers and sisters (NSW, Qld, Vic); a parent, undefined (Qld, Vic); a parent whether biological, step or adoptive (NSW); and

BOX 10.3[10]
ETHICAL DECISION-MAKING ON BEHALF OF CHILDREN AND DEPENDENT ADULTS

Decisions to permit a child or dependent adult to be a living donor will be ethically acceptable only where:

a) the risks and discomforts to the donor are minimal and the tissue is regenerative;
b) the donation is to a person with whom the donor has an intimate or ongoing relationship (ie a close relative);
c) the donation is a last resort in treatment for the recipient;
d) there are no alternative donors;
e) the proposed transplant is of proven efficacy and of great expected benefit to the recipient;
f) there is an independent judgement that the donation is in the donor's overall best interests;
g) the parents or guardians consent and the child or dependent adult (if she or he is able to do so) agrees or assents; and
h) where required by law, a Court or tribunal authorisation has been obtained to undertake a non-therapeutic procedure on a child or dependent adult on the basis that the procedure is in his or her interests.[13]

unspecified but must be specified in the consent (SA). In most cases the requirements are extremely onerous.

Only the Australian Capital Territory makes provision for the removal of non-regenerative tissue from a child for transplantation and this is in contrast to the NHMRC advice above. The Northern Territory legislation is silent on the matter, and other jurisdictions, such as Victoria, expressly prohibit removal of non-regenerative tissue from a child.

Removal of blood

ADULTS

Consent to the removal of blood from adults is relatively non-controversial. Section 18 of the *Human Tissue and Transplant Act 1982* (WA) contains the following provision:

> A person who —
>
> a) has attained the age of 18 years; and
> b) is of sound mind, may consent to the removal of blood from his body for transfusion to another person or for use of the blood or of any of its constituents for other therapeutic purposes or for medical or scientific purposes.

Most of the statutes have a similar format.

CHILDREN

With the exception of the Northern Territory legislation, which is silent on the matter, all statutes make provision for a parent to give consent to the removal of blood from a child, usually with some provision for a medical practitioner to provide an assurance that the removal will not be harmful to the child and, in most cases, with the agreement of the child. Section 20A of the *Human Tissue Act 1983* (NSW) makes specific provision for where the child is too young to be able to agree. This provision is unusual and so is set out in full:

> **Section 20A Consent to removal of blood from child if child unable to agree**
>
> A parent or guardian of a child who is under the age of 16 years may consent in writing to the removal of blood from the child's body without the consent of the child for the purpose of using the blood in the treatment of the child's parent (being the biological parent, step-parent or adoptive parent), brother or sister, but that consent is only effective if:
>
> a) a medical practitioner (other than the medical practitioner responsible for treating the child's parent, brother or sister) certifies in writing that, in the opinion of the medical practitioner:
>
> i) the child is unable to understand the nature and effect of the removal of blood from the child's body, and
>
> ii) any risk to the child's health (including psychological and emotional health) caused by the removal of the blood is minimal, and
>
> b) a medical practitioner certifies in writing that the parent, brother or sister is likely to die or suffer serious damage to his or her health unless blood removed from the child is used in the treatment.

Donation of tissue after death

In the past, prior to artificial ventilation or perfusion, if the heart and/or lungs failed, adequate tissue perfusion would automatically cease. Although the individual cells of the body would continue to function until the remaining cellular oxygen supply was used up, there would have been nothing more that could be done to save a person's life.[14] The person would have been dead, and clinically recognisably dead. Thus death could be defined as and determined by the failure of tissue perfusion, or what was commonly referred to as 'cardiac death'.

However, today, with the introduction of chemical and electrical cardiac stimulation, increased knowledge of cellular physiology and artificial ventilation, tissue perfusion need not necessarily cease. So tissue perfusion may be prolonged, if not indefinitely, at least for considerably longer than might previously have been anticipated.

This understanding that a person may not independently be able to sustain circulation or respiration and yet might be kept perfused by artificial, scientific means required a re-definition of death. Death no longer necessarily occurred when a patient stopped breathing or their heart stopped beating — the brain would have to have suffered tissue anoxia for death to occur. As long ago as 1968 a committee

of the Harvard Medical School published a set of criteria for determining when death had occurred, which recommended that death should be understood in terms of a 'permanently non-functioning brain'.[15] It has been necessary to clarify this situation in statute to enable perfused organs to be removed from patients who were recognised to be brain dead. As Windeyer J observed in *Mount Isa Mines Ltd v Pusey,* 'Law march[es] with medicine but in the rear and limping a little'.[16]

All the statutes except the *Transplantation and Anatomy Act 1983* (SA) and the *Human Tissue and Transplant Act 1982* (WA) provide a definition of death which includes a definition of brain death. All the statutes use similar if not identical language. For example, section 27A of the Tasmanian *Human Tissue Act 1985* states that death occurs when:

> For the purposes of the law of Tasmania, a person has died when there has occurred —
>
> a) irreversible cessation of all function of the brain of the person; or
>
> b) irreversible cessation of circulation of blood in the body of the person.

The mechanisms for the determination of brain death may also be included in the legislation. Alternatively, a specific protocol should be established in line with accepted international medical practice. The question of when brain death has occurred and how it should be diagnosed continues to be a topic of significant controversy.[17] The Australian and New Zealand Intensive Care Society (ANZICS) has undertaken excellent work recently and released *The ANZICS Statement on Death and Organ Donation.*[18] ANZICS states that the main purposes of the statement are:

- to provide a standard for intensivists and other healthcare workers in relation to the determination of death and the conduct of organ and tissue donation, including donation after cardiac death (DCD); and
- to provide assurance to the Australian and New Zealand communities that determination of death and the conduct of organ and tissue donation are undertaken with diligence, integrity, respect and compassion, and in accordance with available medical evidence and societal expectations.[19]

Ongoing difficulties with organ donation

Although tissue transplantation is extremely successful, there are still difficulties in relation to the availability of organs, particularly in relation to donation after death. All statutes make provision for the donation of tissue after death. Under section 26 of the *Human Tissue Act 1982* (Vic) where a person has died in hospital or where the body has been brought to the hospital, a designated officer may authorise the removal of tissue for transplantation or other scientific or medical or therapeutic purposes where:

- the deceased person had, at any time, in writing, or during his last illness, orally in the presence of two witnesses, expressed the wish for, or consented to, the removal after his death of tissue from his body for such a purpose or use;

- where the senior available next of kin of the deceased person makes it known to the designated officer that he consents to the removal of tissue from the body of the deceased person for such a purpose or use; or
- where the designated officer, after making such inquiries as are reasonable in the circumstances, is unable to ascertain the existence or whereabouts of the next of kin of the deceased person and has no reason to believe that the deceased person had expressed an objection to the removal after his death of tissue from his body for such a purpose or use.

The most common forms of agreement in writing in Australia are through the drivers' licence scheme or through organ donor cards. Both these approaches are known as 'opting-in' systems; that is, the person makes a positive decision to become an organ donor. Australia has an Organ Donor Registry (AODR) whose legal status was amended in 2005 to require signed written consent for donation in order to comply with human tissue legislative requirements in each jurisdiction.[20] Other countries have taken a different approach and have implemented an 'opting-out' system, where the body is presumed to belong to the state to be disposed of as it sees fit unless the person states an express wish to the contrary.

Post-mortem examinations

Over the past few years there have been a number of serious incidents relating to the conduct of post-mortem examinations and the retention and/or disposal of human tissue following post-mortem examinations.[21]

The events and subsequent inquiry into the practices at the Institute of Forensic Medicine in Glebe, Sydney, led to the passing of the *Human Tissue and Anatomy Legislation Amendment Bill 2003* which made changes to the *Human Tissue Act 1983* (NSW), the *Anatomy Act 1977* (NSW) and the *Coroners Act 1980* (NSW).[22] The Bill was described as follows:

> These amendments protect the rights of individuals to control what happens to their bodies after their death. They also protect the rights of families to be informed of, and to give consent to, procedures that are undertaken on the bodies of family members who have died. The bill balances this respect for individuals' rights with the recognition that society has some legitimate interest in the use of human tissue, which should not be contingent on an individual's consent. Accordingly, the bill protects the use of tissue for coronial purposes for the investigation of crime and the proper functioning of the judicial system. The bill recognises the importance of medical teaching and research and allows these important interests to be advanced without offending the values of the general community. The bill represents a balance between the benefits that accrue from access to human tissue for therapeutic purposes, research, education and training on the one hand and respect for diverse cultural, religious and individual values and personal autonomy on the other hand.[23]

South Australia[24] and Western Australia[25] also undertook reviews into forensic practices, as did the NHMRC Australian Health Ethics Committee.[26] In 2002 the

Australian Health Ministers' Advisory Council Subcommittee on Autopsy Practice issued *The National Code of Ethical Autopsy Practice*.[27] This code has resulted in a number of states and territories amending their legislation in relation to autopsy (or post-mortem examination as it is most often called) and most statutes have issued revised policy documents to meet the requirements of the national code. Whilst the conduct of post-mortem examinations is unlikely to be part of the experience of undergraduate nursing or midwifery students, or indeed the majority of practising nurses and midwives, nevertheless the conduct of post-mortem examinations and the rights of patients and their relatives in relation to their bodies or the bodies of their loved ones are critical and worrying issues, and nurses and midwives may need to reassure patients and relatives about the changes that have been put in place since the events referred to above occurred.

Assisted reproductive technology (ART) and donation of reproductive tissue

Another area of law that has seen rapid developments over the past 5 years is that of assisted reproductive technology (ART). ART is defined as 'the application of laboratory or clinical technology to gametes (human egg or sperm) and/or embryos for the purposes of reproduction'.[28] Again, this is a highly specialised area of healthcare and it is unlikely that most undergraduate students will work in this area, although it may be of interest to midwives, particularly in antenatal care. However, ART is becoming far more common and is likely to increase with the increasing demographic age of women having their first child, thus it is highly likely that nurses and midwives will encounter parents and children who have been involved in this technology in some way.[29] A brief overview of recent developments in the law is provided, with some further references for the interested reader. The NHMRC website on ART reports as follows:

> There were 70,541 ART treatment cycles reported in Australia and New Zealand in 2009, a 13.9% increase on 2008 and a 48.0% increase on 2005. Of these, 92.4% were in Australian fertility centres and 7.6% were in New Zealand fertility centres. Women used their own oocytes/embryos in more than 95% of treatments (autologous), and 33.8% of all cycles used frozen/thawed embryos. It is estimated that more than 35,000 women undertook autologous ART treatment in Australia and New Zealand in 2009. On average, 1.8 fresh and/or thaw cycles per woman were performed in 2009.[30]

The NHMRC *Ethical Guidelines on the use of Assisted Reproductive Technology in Clinical Practice and Research* (the ART Guidelines) were issued in 2004 by the NHMRC and updated in 2007 to reflect amendments to the *Research Involving Human Embryos Act 2002* (Cth) (the RIHE Act) and the *Prohibition of Human Cloning for Reproduction Act 2002* (Cth) (PHCR Act). The ART Guidelines address both clinical and research aspects of assisted reproductive technology. The guidelines are primarily intended for ART practitioners, researchers, infertility clinic administrators, Human Research Ethics Committees and governments.[31] Current reproductive technologies include the following.

OVULATION INDUCTION

A series of hormone injections will be given to the woman in order to stimulate egg growth and ovulation. If ovulation can be successfully induced, conception may occur naturally.

ARTIFICIAL INSEMINATION

Artificial insemination is used in cases where the male has a low sperm count, a high number of abnormal sperm or the woman has sperm antibodies present in her cervical mucus. Sperm is treated in the laboratory to increase the chances of fertilisation. Large numbers of sperm are then inserted directly into the uterus for easy access to the fallopian tubes.

IVF (IN VITRO FERTILISATION)

IVF is used to treat infertility that arises from blockages of the fallopian tubes, endometriosis, abnormal sperm and some cases of unexplained infertility.

The woman is treated with hormones over a number of weeks to stimulate the growth of several eggs in the ovary. When ripe, the eggs are removed from the ovary and put into a dish with the partner's (or donor's) sperm. The fertilised eggs are then grown in the laboratory for a few days before being placed into the uterus.

GIFT (GAMETE INTRAFALLOPIAN TRANSFER)

This procedure is the same as that for IVF except that fertilisation takes place inside the woman's body. The eggs and sperm are collected and placed directly into the fallopian tubes for fertilisation to occur. GIFT is used for cases of endometriosis, cervical disorders and some types of male infertility. GIFT is suitable only for women with no abnormalities in the fallopian tubes.

ZIFT (ZYGOTE INTRAFALLOPIAN TRANSFER)

This is also the same procedure as IVF except the very early embryo (zygote) is placed directly into the fallopian tube. This procedure is undertaken when there are abnormal sperm and/or problems with the ability of the sperm to fertilise the eggs.

ICSI (INTRACYTOPLASMIC SPERM INJECTION)

This is a technique in which a single sperm is inserted directly into the egg. Eggs are obtained the same way as for IVF and then fertilised by injecting a single sperm into them. The fertilised eggs can be transferred to the woman's fallopian tubes or grown in the laboratory for a couple of days and then transferred to the uterus.

EPIDIDYMAL AND TESTICULAR SPERM EXTRACTION

Sperm are removed from the epididymis or directly from the testis using a needle. Fertilisation is performed by ICSI (see above). This treatment is used in cases of male infertility (azoospermia) and spermatic cord abnormalities. Usually enough sperm can be collected so that samples can be frozen for later use if required.

FREEZING OF SPERM AND EMBRYOS

If more embryos are produced through IVF than are needed for transfer into the uterus of the patient, the extra embryos can be frozen. The stored embryos can be

used later if the patient fails to become pregnant or if the couple wishes to have more children through IVF at a later date.

There is a limit to the number of years embryos can be stored frozen and laws governing this may differ in each state. Similarly, sperm can be frozen for use in subsequent IVF cycles or as insurance against infertility due to procedures such as cancer therapies, vasectomy or prolonged absence from a partner (such as men in military service may experience). Sperm can also be frozen and kept in sperm donor banks.

DONOR EGGS, EMBRYOS AND SPERM

For women who have ovarian failure, men who do not produce sperm, or couples whose eggs fail to fertilise, the use of donor eggs, embryos or sperm may be an option. Older women may also wish to use donor eggs from younger women to overcome the problems of ageing.[32]

Although the use of ART has been increasing since the first Australian IVF baby was born in 1980, there is still concern about the lack of accurate data on success rates in terms of live, healthy births and the overly optimistic attitude the community seems to have towards ART as a complete and infallible solution for infertility.[33] Clearly the development of these techniques has raised a range of ethical and legal challenges over time, including the need to determine parentage, the question of payment for donors and surrogates, and even more potentially controversial issues such as cloning.

CONCLUSION

This chapter has examined the provisions of the various pieces of legislation dealing with human tissue transplantation and explored some of the ethical and clinical dilemmas inherent in the developments of these technologies. In addition, the chapter has briefly examined the law relating to assisted reproductive technologies and some of the current issues in relation to post-mortem practice in Australia. The chapter has provided a wide range of guidance documents and resources with further information on these complex and developing areas as there is no doubt that these issues will prove to be challenges for law and ethics in the future and will require serious thought as the readers progress in their nursing careers.

Endnotes

Note: All links given below were last accessed on 20 January 2012.

1) Scott R, *The Body as Property*, Allen Lane, London, 1981.
2) Ibid.
3) Herring J, *Medical Law and Ethics*, 3rd ed, Oxford University Press, Oxford, 2010, p 419.
4) Australian Associated Press, 'Record number of organ donors in 2011', *Nursing Review*, 2011, http://www.nursingreview.com.au/pages/section/article.php?s=Breaking+News&idArticle=22961.
5) Australian Law Reform Commission, Report no. 7, *Human Tissue Transplants*, AGPS, Canberra, 1977, http://138.25.65.50/au/other/alrc/publications/reports/7/4_Foreword.html.
6) *Transplantation and Anatomy Act 1978* (ACT); *Human Tissue Act 1983* (NSW);

Transplantation and Anatomy Act 2011 (NT); *Transplantation and Anatomy Act 1979* (Qld); *Transplantation and Anatomy Act 1983* (SA); *Human Tissue Act 1985* (Tas); *Human Tissue Act 1982* (Vic); *Human Tissue and Transplant Act 1982* (WA).

7) Bellomo R and Zamperetti N, 'Defining the vital condition for organ donation', (2007) *Philosophy, Ethics, and Humanities in Medicine* 2:27, http://www.peh-med.com/content/2/1/27.

8) Goold I, 'Sounds suspiciously like property treatment: Does human tissue fit within the common-law concept of property?' (2006) *University of Technology Sydney Law Review* 3.

9) National Health and Medical Research Council (NHMRC), *Organ and Tissue Donation by Living Donors: Guidelines for Ethical Practice for Health Professionals,* 2007, http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/e71.pdf.

10) NHMRC, *Making a Decision about Living Organ and Tissue Donation*, 2007, http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/e70.pdf.

11) NHMRC, *Organ and Tissue Donation by Living Donors: Guidelines for Ethical Practice for Health Professionals*, 2007, http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/e71.pdf, p 6.

12) NHMRC, *Making a Decision about Living Organ and Tissue Donation*, 2007, http://www.nhmrc.gov.au_files_nhmrc/publications/attachments/e70.pdf, p 5.

13) NHMRC, *Organ and Tissue Donation by Living Donors Guidelines for Ethical Practice for Health Professionals*, 2007, http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/e71.pdf, p 27.

14) Mason J K and McCall Smith R A, *Law and Medical Ethics*, Butterworths, London, 1987, p 209.

15) Ad Hoc Committee of the Harvard Medical School to examine the definition of brain death: a definition of irreversible coma (1968) *Journal of the American Medical Association* 205: 337–40.

16) *Mount Isa Mines Ltd v Pusey* (1970) 125 CLR 383 at 395.

17) Bernat J, 'How the distinction between "irreversible" and "permanent" illuminates circulatory–respiratory death determination', (2010) *Journal of Medicine and Philosophy* 35 at 242–55.

18) Australian and New Zealand Intensive Care Society (ANZICS), *The ANZICS Statement on Death and Organ Donation*, edition 3.1, ANZICS, Melbourne, 2010.

19) Ibid, p 9.

20) Ibid, p 34.

21) Redfern M, QC, *The Report of the Royal Liverpool Children's Inquiry*, House of Commons, London, 2001; Walker B, *Report into Post-mortem and Anatomical Examination Practices of the Institute of Forensic Medicine*, New South Wales Government, Sydney, 2002.

22) Burton C (Parliamentary Secretary), Hansard extract, New South Wales Legislative Assembly, 28 May 2003 (article 5), http://www.parliament.nsw.gov.au/prod/parlment/hansart.nsf/V3Key/LA20030528005.

23) Ibid.

24) Selway B M, QC, Report into the retention of body parts after post-mortems (sic), Solicitor General South Australia, 6 August 2001, (unpublished) cited in The Royal College of Pathologists of Australasia, *Policy: Autopsies and the Use of Tissues Removed from Autopsies*, Approval Date: July 1993, Revised: October 2002, no. 1 of 1993, http://www.rcpa.edu.au/static/File/Asset%20library/public%20documents/Policy%20Manual/Policies/Autopsies%20and%20the%20Use%20of%20Tissues%20Removed%20from%20Autopsies.pdf.

25) Kucera B (Minister for Health), Western Australian Government Hansard, 2001, p 4495. See also, Hansard, Thursday 13 April 2006 per The Hon. Giz Watson, http://www.parliament.wa.gov.au/hansard.

26) NHMRC, Australian Health Ethics Committee, *Organs Retained at Autopsy — Ethical and Practical Issues*, Commonwealth of Australia, Canberra, 2001.

27) Australian Health Ministers' Advisory Committee, Subcommittee on Autopsy Practice, *The National Code of Ethical Autopsy*, South Australian Department of Human Services, Adelaide, 2002.

28) NHMRC, 'Assisted Reproductive Technology (ART)', 2011, http://www.nhmrc.gov.au/health-ethics/australian-health-ethics-committee-ahec/assisted-reproductive-technology-art/assisted-.

29) O'Connor V and Johnson K, 'Editorial: Delaying childbearing — ensuring life choices are informed', (2005) *Australian Family Physician* 34 (3); Quinn F, 'We are having trouble conceiving …', (2005) *Australian Family Physician* 34 (3), http://www.racgp.org.au/afp/200503/13314; Mounce G, 'Assisted reproduction: What do midwives need to know?' *Midwives*, 2009, http://www.rcm.org.uk/midwives/in-depth-papers/assisted-reproduction-what-do-midwives-need-to-know/.

30) NHMRC, 'Assisted Reproductive Technology (ART)', 2011, http://www.nhmrc.gov.au/health-ethics/australian-health-ethics-committee-ahec/assisted-reproductive-technology-art/assisted-.

31) Yang Y A et al., 'Assisted Reproductive Technology in Australia and New Zealand', *Australian Policy Online*, 2009, http://apo.org.au/research/assisted-reproductive-technology-australia-and-new-zealand-2009.

32) McArthur S, 'Infertility Fact File: ABC Health and Wellbeing Online', 2011, http://www.abc.net.au/health/library/stories/2007/05/30/1919840.htm#p3-.

33) Bell K, 'An overview of assisted reproduction in Australia and directions for social research', (2006) *Australian Journal of Emerging Technologies and Society* 4 (1) at pp 15–27, http://www.swinburne.edu.au/hosting/ijets/journal/V4N1/V4N1abstract_bell.htm.

Chapter 11

Mental health

In the development of modern day healthcare systems overborne by advances in science and technology, the provision of care and treatment for people suffering from mental illness has had a chequered and somewhat shameful history. From the early beginnings of European settlement in Australia until comparatively recent times, the provision of mental health services for those in need has been characterised by social stigma, community rejection and custodial institutional care.

Fortunately progress has been made. The community at large is slowly recognising that mental health is as important as physical health in the development of better individual and community health strategies. In addition, a lot of the stigma attached to mental illness is slowly being eroded by public education and informed debate. There has also been a move in some states and territories to separate the care of the mentally ill from those deemed to be developmentally disabled (also referred to as intellectually handicapped or intellectually disabled) where it is possible. More and more, where the patient's condition permits, mental healthcare is moving away from long-term institutional care to community care and treatment. As a result, mental health legislation in most of the states and territories is now reflecting that trend, providing for a variety of community-oriented care and treatment orders.

The framework for the provision and regulation of mental health services is embodied in legislation. All of the states and territories have reviewed their mental health legislation and effected considerable changes consistent with the United Nation's Principles for the Protection of Persons with Mental Health Care, the Australian Health Minister's Mental Health Statement of Rights and Responsibilities, and the National Mental Health Plan.

The Australian Government was a major contributor in drafting the abovementioned United Nation's Principles, which were adopted by resolution of the United Nation's General Assembly in 1991.

The principles stipulate that all persons have the right:

- to the best available mental healthcare;
- to be treated with humanity and respect for the inherent dignity of the human person;

- to protection from economic, sexual and other forms of exploitation, physical or other abuse, and degrading treatment;
- to be free of discrimination;
- to exercise all civic, political, economic, social and cultural rights.

There are also more specific, detailed provisions contained within the principles, asserting matters such as restrictions on involuntary detention, the right to judicial review of detention as well as the objective of the least restrictive environment for treatment purposes.

The National Mental Health Statement of Rights and Responsibilities was adopted by all states and territories in 1991. The statement essentially restates the rights and objectives encompassed within the United Nation's Principles. To support the National Mental Health Statement the states and territories endorsed the National Mental Health Plan in 1992. The aims of that process are to:

- set a clear direction for the future development of mental health services in Australia;
- promote the mental health of Australians and, where possible, prevent the development of mental health problems and mental disorders;
- reduce the impact of mental disorders on individuals, families and the community; and
- establish a framework to ensure the rights of people with mental illness are protected.

The above activities have acted as the impetus for significant changes in mental health legislation in each of the states and territories.

As is common with most healthcare legislation in Australia, the mental health legislation varies between the states and territories. Most now have separate, but complementary, legislation in relation to people with intellectual or other disabilities as distinct from mental illness. South Australia deals with intellectual disability as well as traditional psychiatric illness in its mental health legislation. In the Australian Capital Territory the distinction is not specifically addressed and is presumably left to the treating psychiatrist or officially determined guidelines to determine who does or does not come under the provisions of the legislation for the purposes of determining treatment.

All of the states and territories are quite clear and specific in their legislative objectives, based predominantly on the principles identified in the National Mental Health Statement. For example, section 3 of the New South Wales *Mental Health Act 2007* spells out the objects of the Act in relation to the care, treatment and control of mentally ill and mentally disordered persons as follows:

1) The objects of this Act are:
   a) to provide for the care, treatment and control of those persons who are mentally ill or mentally disordered, and
   b) to facilitate the care, treatment and control of those persons through community care facilities, and

c) to facilitate the provision of hospital care for those persons on a voluntary basis where appropriate and, in a limited number of situations, on an involuntary basis, and
d) while protecting the civil rights of those persons, to give an opportunity for those persons to have access to appropriate care, and
e) to facilitate the involvement of those persons and persons caring for them, in decisions involving appropriate care, treatment and control.

As well as the above provisions, reference should be made to section 68 of the Act that contains the principles underpinning the care and treatment of a person with a mental illness or mental disorder. As well, section 105 sets out the objectives for the New South Wales public health system in relation to the delivery of mental health services.

All of the states and territories have enshrined similar objectives into their legislation.

Legislative approach

The legislation in each of the states and territories tends to follow a similar pattern by making provision, to a greater or lesser degree, under the following relevant subject areas:

- definition of what persons come within the legislation for the purposes of care, treatment and control;
- the process which must be followed to admit, detain and treat persons under the legislation;
- provision for the types of treatment which may be given under the legislation and the processes to be followed to do so;
- the recognition of fundamental rights of persons admitted, detained and treated under the legislation; and
- provision of appropriate review and appeal mechanisms to ensure that persons are not inappropriately detained and, that while they are detained, their civil rights are protected.

A summary of, and comments on, the *Mental Health Act* of each state and territory follows, highlighting the most important areas for nursing staff, particularly in relation to the abovementioned subject areas. As always, nurses working in the area of mental health should take the time to become familiar with the legislation relevant to their state or territory.

Australian Capital Territory: *Mental Health (Treatment and Care) Act 1994*

DEFINITIONS

With some exceptions, the dictionary at the end of the Act contains relevant definitions. Unlike a majority of the other states, the ACT Act deals with persons with a mental illness as well as persons with an intellectual disability (referred to in the

Act as a 'mental dysfunction'). The dictionary provides the definitions of 'mental dysfunction' and 'mental illness' in the following terms:

> ***mental dysfunction*** means a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion.
>
> ***mental illness*** means a condition that seriously impairs (either temporarily or permanently) the mental functioning of a person and is characterised by the presence in the person of any of the following symptoms:
>
> a) delusions;
> b) hallucinations;
> c) serious disorder of thought form;
> d) a severe disturbance of mood;
> e) sustained or repeated irrational behaviour indicating the presence of the symptoms referred to in paragraph (a), (b), (c) or (d).

Section 5 of the Act provides that a person is not to be deemed to be suffering from mental dysfunction or mental illness by reason only that the person expresses, or refuses or fails to express, an opinion in relation to politics, religion, law or morals, or engages, or refuses or fails to engage, in a particular political, religious, illegal or immoral conduct or anti-social behaviour or takes alcohol or any other drug.

References to ACAT throughout the Act are references to the Australian Capital Territory Civil and Administrative Tribunal established pursuant to the *Civil and Administrative Tribunal Act 2008* (ACT). ACAT is the acronym used in the Act to refer to the tribunal that hears and determines applications and reviews under the Act in relation to both mentally dysfunctional and mentally ill persons.

ADMISSION TO AND DETENTION IN A MENTAL HEALTH FACILITY

When dealing with admissions the Act refers to a person being taken to a 'mental health facility', defined in the dictionary as follows:

> … a facility for the treatment, care, rehabilitation or accommodation of mentally dysfunctional or mentally ill persons, and includes a psychiatric institution.

Part 12, which deals with the licensing of private health facilities (ss 123–135), defines a 'psychiatric institution' for the purposes of that part of the Act only.

Voluntary application for a mental health order

Section 10 makes provision for a mentally ill or mentally dysfunctional person to apply for a mental health order on his or her own behalf. The dictionary of the Act defines a 'mental health order' as a psychiatric treatment order, a community care order or a restriction order.

In making an application for such an order on a voluntary basis, the person is submitting themselves to the powers of ACAT (the tribunal) to make such an order.

Application by other people for an involuntary mental health order

Section 11 of the Act permits a person, the 'applicant', to make an application to the tribunal for a mental health order in respect of another person if the applicant believes on reasonable grounds that the health and safety of the person is at risk because the person is unable, due to mental dysfunction or mental illness:

- to make reasonable judgments about matters relating to his or her own health or safety; or
- to do anything necessary for his or her health or safety; or
- is likely to do serious harm to others.

Assessment order and making of a mental health order

Before the tribunal makes any mental health order, the person must be assessed and the tribunal is required to consider that assessment (s 23). An assessment order may be made by the tribunal if satisfied on the face of the application that the person is mentally dysfunctional or mentally ill and the person's health or safety is likely to be at risk and the person is likely to do serious harm to others (s 16).

An assessment order must contain details of where and, if appropriate, by whom the assessment is to be conducted. A person may be admitted to a mental health facility for an assessment to be undertaken (s 19). Following the assessment, the tribunal is required to hold an inquiry (s 24).

Section 26 provides a comprehensive listing of those matters the tribunal must take into account in making a mental health order. For example, section 26(a) provides that the tribunal must consider whether the person consents, refuses to consent, or has the capacity to consent, to a proposed course of treatment, care or support.

Once it has considered all the matters identified in section 26, the tribunal, as it considers appropriate, may make one of the following three types of mental health orders:

1) psychiatric treatment order;

2) restriction order;

3) community treatment order.

A psychiatric treatment order permits the tribunal to order the involuntary psychiatric treatment of a person if it considers the person has a mental illness and is likely to harm himself or herself or others and the tribunal is satisfied the treatment will help reduce the risk of further deterioration in the person's condition and the treatment cannot be provided in a less restrictive environment (s 28).

The psychiatric treatment order may stipulate the mental health facility the person is to be taken to as well as the treatment (other than electroconvulsive therapy and psychiatric surgery), counselling, therapeutic or rehabilitation programs the person should receive. The order may place limits on who the person may communicate with and it must include a statement indicating that the person the subject of the order has the capacity to consent to the making of the order and does so, *or* has the capacity to consent but refuses to do so, *or* does not have the capacity to consent (s 29).

A restriction order, which in most circumstances would be made concurrent with a psychiatric treatment order, permits the tribunal to order where the person is to live or a place where he or she is to be detained (s 31).

For a mentally dysfunctional person a community treatment order may be made where the tribunal has reasonable grounds for believing that, because of the mental dysfunction, the person is likely to harm himself or herself or others or suffer a serious deterioration in his or her mental or physical wellbeing unless an involuntary treatment order is made. As well, the tribunal must be satisfied that the psychiatric treatment order should not be made and that the care and treatment required cannot be given other than by an involuntary order (s 36). Such an order may stipulate the treatment, medication and other programs the person is to undergo and may limit who the person may communicate with (s 36A).

A restriction order may be made in conjunction with a community care order, requiring the person to live in a community care facility or another place (s 36B).

A psychiatric treatment order or a community care order has effect for a period of 6 months or a shorter period, if so specified. A restriction order has effect for 3 months or a shorter period, if so specified.

The tribunal has the power, on application or on its own initiative, to review a mental health order. In doing so, the tribunal may vary or revoke an order, make an additional mental health order, or order a further assessment of the person (s 36L).

Emergency admissions

In respect of emergency admissions, section 37(2) provides that a medical practitioner or an authorised mental health officer may take a person to an approved health facility for admission if either of those persons has reasonable grounds for believing that:

a) a person is mentally dysfunctional or mentally ill and—
   i) as a consequence, requires immediate treatment or care; or
   ii) in the opinion of the doctor or mental health officer, the person's condition will deteriorate within 3 days to such an extent that the person would require immediate treatment or care;
b) the person has refused to receive that treatment or care; and
c) detention is necessary for the person's own health or safety, social or financial wellbeing, or for the protection of members of the public; and
d) adequate treatment or care cannot be provided in a less restrictive environment;

[in which case] the doctor or mental health officer may apprehend the person and take him or her to an approved health facility.

An authorised mental health officer for the purposes of the Act is a person appointed as such by the minister and is either a nurse, nurse practitioner, psychologist, occupational therapist or social worker (s 119).

Section 37(1) provides that a police officer may apprehend and take a person to an approved health facility and in doing so may use such force and assistance as he

or she considers necessary where the police officer has reasonable grounds for believing that a person is mentally dysfunctional or mentally ill and has attempted or is likely to attempt:

a) to commit suicide; or
b) to inflict serious harm on himself or herself or another person.

Where a person is taken to an approved health facility the person in charge is able to detain that person. Under the provisions of section 38, while a person is so detained, the person in charge:

a) may keep the person in such custody as the person in charge thinks appropriate; and
b) may subject the person to such confinement as is necessary and reasonable—
   i) to prevent the person from causing harm to himself or herself or to another person; *or*
   ii) to ensure that the person remains in custody; *and*
c) may subject the person to such restraint (other than confinement) as is necessary and reasonable—
   i) to prevent the person from causing harm to himself or herself or to another person; *or*
   ii) to ensure that the person remains in custody. [emphasis added]

ACAT must, on application, review a decision to detain a person within 2 working days after the application is made (s 37).

Any police officer, medical practitioner or mental health officer who takes a person to an approved health facility for detention is required to provide a statement setting out the details of the action taken and reasons for taking it and file the statement with the person's clinical records (s 39).

Continued detention following emergency admission

A person who is detained by way of an emergency admission must be examined by a medical practitioner within 4 hours of admission to an approved health facility (s 40). Where the medical practitioner believes that further detention is necessary he or she may authorise involuntary detention and care for a period not exceeding 3 days (s 41(1)). Section 42 requires that within 12 hours of admission the office of the Public Advocate and the tribunal are to be notified. If a further period of involuntary detention is required beyond the initial 3 days, the tribunal must extend that period of detention and can only do so in the first instance for a further 7 days (s 41(2)).

Following the initial period of involuntary detention after an emergency admission, the tribunal is required to have the person assessed prior to the holding of an inquiry and the making of any mental health order.

The Act is concerned to ensure that any person who is admitted to a mental health facility for the purposes of treatment and pursuant to a mental health order is to have access to his or her lawyer and to the Public Advocate at any time. The person in charge of a mental health facility is required to provide whatever assistance

is necessary to ensure access by the lawyer or Public Advocate to the person who is being detained following assessment orders being made (s 20).

The obligations of the tribunal

In making such orders as those detailed above, the tribunal is required to have regard to one of the overriding objectives of the Act — for persons in need of care to be treated within a community environment. The Act gives considerable emphasis to this objective, in particular in section 8, the relevant part of which states:

> In providing services and facilities for mentally dysfunctional or mentally ill persons, the Territory shall have regard to the following objectives:
>
> a) to establish, develop, promote, assist and encourage services and facilities—
>
> …
>
> vii) that support mentally dysfunctional or mentally ill persons in the community and coordinate with other community services …

In addition, in detailing those matters which the tribunal is required to take into account in making a mental health order, section 26(i) states that the tribunal shall take into account:

> i) that, as far as possible, the person should live in the general community and join in community activities …

Obviously, the power of the tribunal to make a community care order facilitates such an objective.

Electroconvulsive therapy (ECT) and psychiatric surgery

Part 7 of the Act deals with what is referred to as electroconvulsive therapy (ECT) and psychiatric surgery. Those terms are defined as follows:

- 'electroconvulsive therapy' means a procedure for the induction of a epileptiform convulsion in a person (s 55);
- 'psychiatric surgery' means surgery on the brain of a person other than neurosurgery (dictionary to the Act).

Both definitions are referred to by the general terminology of 'procedure' for the purposes of this part of the Act.

Section 54(1) details the conditions which have to be fulfilled for the purposes of this part of the Act where a person is required to give 'informed consent' to a procedure. Those conditions are as follows:

> a) the person has been given a clear explanation of the procedure that contains sufficient information to enable the person to make a balanced judgment about whether or not to consent to the procedure; and
> b) the person has been given an adequate description (without exaggeration or concealment) of the benefits, discomfort and risks involved in the procedure; and
> c) the person has been advised of all alternative treatments reasonably available that may be of benefit to the person; and

d) the person has been given an opportunity to ask any questions about the procedure, those questions have been answered and the person appears to have understood the answers; and
e) a full disclosure has been made to the person of any financial relationship between the person seeking to obtain the consent, the doctor who is proposing to conduct the procedure or both (as the case may be) and the psychiatric institution at which it is proposed to conduct the procedure; and
f) the person has been given, has read and appears to have understood a notice stating that—
   i) the person has the right to obtain independent legal and medical advice and any other independent advice or assistance before giving informed consent; *and*
   ii) the person is free to refuse or withdraw consent and to have the procedure discontinued at any time; *and*
g) the person has been given an information statement. [emphasis added]

Electroconvulsive therapy

The administration of ECT with consent (s 55A):

- must be administered by a medical practitioner;
- informed consent must be given and not have been withdrawn;
- must not be administered on more than 10 occasions since the informed consent was given.

Administration of ECT to a person without consent (s 55B)

An offence is committed if a doctor administers ECT without the informed consent of the person. However, the tribunal may make an ECT order as part of a psychiatric treatment order with the person's informed consent or on an involuntary basis (s 55G). The latter situation occurs where the tribunal is satisfied that the person is, by reason of mental illness, incapable of weighing for himself or herself the considerations involved in making a decision whether or not to consent to the administration of convulsive therapy and the tribunal is satisfied that:

- the administration of the therapy is likely to result in substantial benefit to the person; *and*
- it is the most appropriate form of treatment reasonably available; and
- all other forms of treatment have been tried and have not been successful.

Records must be kept of all ECT treatments administered (s 57) and must be kept for 5 years (s 58).

Psychiatric surgery

Application must be made in writing by a medical practitioner to the Chief Psychiatrist of the Australian Capital Territory seeking approval to undertake psychiatric surgery (s 61). On receipt of that application the Chief Psychiatrist is

required (s 62) to submit the application to a committee, appointed by the Minister of Health, for their consideration. The committee referred to in section 62 is set up under the provisions of section 67 of the Act and consists of:

- a psychiatrist;
- a neurosurgeon;
- a legal practitioner;
- a clinical psychologist; *and*
- a social worker.

In considering the application for psychiatric surgery, the committee, in recommending that the Chief Psychiatrist should approve the psychiatric surgery proposed in the application, must be satisfied (s 62(3)) that:

- there are reasonable grounds for believing that the performance of the surgery will result in substantial benefit to the person on whom it is proposed to be performed; *and*
- all alternative forms of treatment reasonably available have failed or are likely to fail to benefit the person; *and*
- the recommendation is supported by the psychiatrist and the neurosurgeon on the committee.

In addition to the above, a medical practitioner may make application to the Supreme Court of the Australian Capital Territory seeking its consent to the performance of psychiatric surgery on a person (s 65).

A person who has given informed consent to the performance of psychiatric surgery or who is the subject of a Supreme Court Order in respect of such a procedure may withdraw that consent at any time orally or in writing (s 66).

PATIENT RIGHTS, REVIEW OF CARE AND APPEAL MECHANISMS UNDER THE ACT

Sections 7 and 8 set out in some detail the objectives both of the Act and of the Australian Capital Territory in the provision of mental health services. In particular, section 7 states that the objectives of the Act are:

a) to provide treatment, care, rehabilitation and protection for mentally dysfunctional or mentally ill persons in a manner that is least restrictive of their human rights;
b) to provide for mentally dysfunctional or mentally ill persons to receive treatment, care, rehabilitation and protection voluntarily and, in certain circumstances, involuntarily;
c) to protect the dignity and self-respect of mentally dysfunctional or mentally ill persons;
d) to ensure that mentally dysfunctional or mentally ill persons have the right to receive treatment, care, rehabilitation and protection in an environment that is the least restrictive and intrusive, having regard to their needs and the need to protect other persons from physical and emotional harm;

e) to facilitate access by mentally dysfunctional or mentally ill persons to services and facilities appropriate to the provision of treatment, care, rehabilitation and protection.

Sections 49 to 53 of the Act detail the rights of mentally dysfunctional and mentally ill persons in the provision of care and treatment. For example, section 50 requires that on admission to a mental health or community care facility a person is entitled, and is required to receive, oral advice as to his or her rights under the Act and a copy of a statement which contains:

- a prescribed statement setting out the rights and entitlements of persons under the Act, including the right to obtain legal advice and seek a second opinion from an appropriate mental health professional; *and*
- any other information relating to the treatment and care of the person that the minister considers relevant.

Section 50 also requires that such information should be in a language that the person is familiar with and if it appears that the person is unable to understand the written information, every effort is to be made to translate that into a language that they do understand. Further, the Public Advocate's office is to be informed of difficulties experienced by the person in understanding the information.

Section 51 requires that the person who is being detained in a mental health or community care facility has access to a wide range of documentary material specified in the section as well as the names, addresses and telephone numbers of the various statutory authorities available to a person who may be seeking assistance in relation to their legal rights under the Act.

As referred to earlier, the office of the Public Advocate is required under the Act to be notified within 12 hours of a person's detention in an approved mental health or community care facility. The Public Advocate as well as the person's legal representative is to be given free and unfettered access to a person detained in a mental health or community care facility pursuant to an assessment order in the territory (s 22C).

APPEAL RIGHTS

Section 141 of the Act provides for a right of appeal from an order made by the Mental Health Tribunal to the Supreme Court of the Australian Capital Territory. Appeals may be brought by:

- somebody in relation to whom the decision was made;
- a person who appeared or who was entitled to appear before ACAT in the proceedings under appeal;
- the Discrimination Commissioner;
- anyone else with leave of the Supreme Court.

OFFICIAL VISITORS

Section 121 provides for the appointment of 'official visitors'. The functions and duties of official visitors are set out in section 122 of the Act, which requires official visitors to visit and inspect mental health facilities and inquire into:

- the adequacy of services for the assessment and treatment of persons with mental dysfunction or a mental illness; and
- the appropriateness and standard of facilities for the recreation, occupation, education, training and rehabilitation of persons receiving treatment or care for mental dysfunction or a mental illness; and
- the extent to which people receiving treatment or care for mental dysfunction or a mental illness are being provided the best possible treatment or care appropriate to their needs in the least possible restrictive environment and least possible intrusive manner consistent with the effective giving of that treatment or care; and
- any contravention of the Act; and
- any other matter that an official visitor considers appropriate having regard to the objectives in sections 7 and 8; and
- any complaint made to an official visitor by a person receiving treatment or care for mental dysfunction or a mental illness.

In exercising their powers and functions official visitors may visit any mental health facility with or without notice and must do so at least once every 3 months. When visiting such a facility, an official visitor may inspect any part, see any person receiving care, make any inquiries about persons in care and inspect documents or records. It is an offence, without reasonable excuse, to refuse to assist or to obstruct an official visitor exercising his or her powers under the Act (s 122A).

An official visitor is required to provide a report to the minister and the Public Advocate (s 122B).

Inspectors appointed in relation to private mental health facilities

The Act makes provision for the appointment of persons known as 'inspectors' in relation to the control and licensing of private mental health facilities under the Act. Section 132 provides that the Minister of Health may appoint such inspectors as are considered necessary. Section 134(1) provides that an inspector may, at any hour of the day, enter any licensed premises and:

a) inspect the premises and any equipment used at the premises in connection with the treatment, care, rehabilitation or accommodation of patients or residents; and
b) inspect any books, documents or other records that are in possession of the occupier of the premises, or to which the occupier has access, relating to the conduct of the psychiatric institution at those premises; *and*
c) require the occupier of the premises to furnish the inspector with any information, books, documents or other records that are in the possession of the occupier, or to which the occupier has access, relating to the conduct of the psychiatric institution at those premises. [emphasis added]

Any person who, without reasonable cause, obstructs or hinders an inspector in the exercise of his or her powers under section 134 is liable to a penalty under the Act (s 135).

New South Wales: *Mental Health Act 2007*

DEFINITIONS

Most legislation will, as a matter of course, have a section of relevant definitions at the commencement of the statute or as a dictionary at the end of it, in the form of a schedule. In the New South Wales Act relevant definitions are set out in section 4.

Probably the most important consideration in mental health legislation is knowing how mental illness is defined. This understanding is necessary to ensure that people are not wrongly detained and/or treated under the provisions of the Act and their civil liberties overruled. The New South Wales definitions relevant to this issue are:

- mental illness;
- mentally disordered person;
- mentally ill person;
- certain words or conduct which may not indicate mental illness or disorder.

The New South Wales Act is somewhat unusual in that it distinguishes between mental illness and a person who is mentally ill; a person may have a mental illness but not necessarily be mentally ill — as the definition makes clear. Also, the Act makes provision for a person who is mentally disordered as distinct from mentally ill. Such a distinction is important to understand as the detention provisions are quite different.

As well, an overriding consideration in determining the need of 'care, treatment or control' for a mentally ill person or a mentally disordered person is whether such a person, as part of that 'care, treatment or control', requires admission and detention. The emphasis in the Act is to use admission and detention only as a last resort rather than the first principle of care. Section 12, which deals with the issue of involuntary admission to hospitals, states that a person must not be admitted involuntarily to, or detained in or continue to be detained in, a mental health facility unless the authorised medical officer believes the person is mentally ill or mentally disordered and that no other care of a less restrictive kind that is consistent with safe and effective care is appropriate and reasonably available to the person.

It follows, therefore, that a mentally ill or mentally disordered person will only be detained in a mental health facility if it is considered that 'no other care of a less restrictive kind is appropriate and reasonably available to the person'.

Mental illness

This definition, found in section 4 of the Act, reads as follows:

> **mental illness** means a condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:
>
> a) delusions,
>
> b) hallucinations,
>
> c) serious disorder of thought form,

d) a severe disturbance of mood,
e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)–(d).

It is important to note that the definition does not include any reference to dementia or developmental disability. The intention is that such conditions are not recognised as a mental illness for the purposes of the New South Wales Act, unless they are accompanied by any of the above symptoms. If not, such people are provided for under specific guardianship laws and, in New South Wales, the relevant legislation is the *Guardianship Act 1987*. Nevertheless, the latter legislation and the *Mental Health Act* are intended to be complementary and a guardianship order can coexist with an order under the *Mental Health Act*. However, the *Mental Health Act* takes precedence where there is an inconsistency.[1]

Mentally ill person

Section 14 of the Act defines such a person as follows:

1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:
   a) for the person's own protection from serious harm, or
   b) for the protection of others from serious harm.
2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.

Remember, the important thing to note here is that the New South Wales Act distinguishes between a person who has a mental illness and a person who is mentally ill. This means that a person who has a mental illness cannot be automatically classified as being mentally ill. The definition of mental illness has to be read in conjunction with the definition of a mentally ill person. Accordingly, for a person to be deemed to be a mentally ill person in New South Wales the following criteria have to be addressed:

a) the person must be suffering from a mental illness as per the definition in section 4 of the Act; *and*
b) there are reasonable grounds for believing that care, treatment and control of the person is necessary for the protection of the person or others from serious harm; *and*
c) the continuing condition of the person including any likely deterioration and the likely effects of such deterioration is to be taken into account as provided in section 14 of the definition of 'mentally ill person'; *and*
d) there is no less restrictive environment in which appropriate care, treatment and control can be safely and effectively provided.[2] [emphasis added]

Mentally disordered person

In addition to defining mental illness and mentally ill persons, the New South Wales Act also provides for a category of person described as 'mentally disordered'. Section 15 defines this category as follows:

> A person (whether or not the person is suffering from mental illness) is a mentally disordered person if the person's behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary:
>
> a) for the person's own protection from serious physical harm, or
>
> b) for the protection of others from serious physical harm.

Note the emphasis that is given in this definition to irrational behaviour 'for the time being' such that 'temporary' care, treatment or control is necessary.

This category is intended to deal with those persons who are not mentally ill as defined in the Act (though they may have a mental illness) but whose behaviour is temporarily irrational and a danger to themselves or others. The best example of a mentally disordered person would be a person suffering a severe personal traumatic crisis in a social or domestic situation where they are unable to control their emotions and may become suicidal. To qualify as a mentally disordered person under the Act the following criteria have to be considered:

a) the person must be displaying irrational behaviour (not necessarily a mental illness); *and*

b) as a result of that behaviour there is a significant risk of serious physical harm to the person or others; *and*

c) temporary care, treatment or control is considered necessary; *and*

d) there is no less restrictive environment in which appropriate care, treatment and control can be safely and effectively provided.[3] [emphasis added]

Note that the Act does not attempt to define 'irrational behaviour' — so it would be a matter of determining whether a person's behaviour was irrational or otherwise having regard to the ordinary use and understanding of the word and the context of the person's behaviour on any particular occasion.

The New South Wales Act also identifies certain words or conduct that, by themselves, may not indicate mental illness or disorder. Section 16 outlines those provisions as follows:

> 1) A person is not a mentally ill person or a mentally disordered person merely because of any one or more of the following:
>
> a) the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular political opinion or belief,
>
> b) the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular religious opinion or belief,
>
> c) the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular philosophy,
>
> d) the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular sexual preference or sexual orientation,

e) the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular political activity,
f) the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular religious activity,
g) the person engages in or has engaged in a particular sexual activity or sexual promiscuity,
h) the person engages in or has engaged in immoral conduct,
i) the person engages in or has engaged in illegal conduct,
j) the person has developmental disability of mind,
k) the person takes or has taken alcohol or any other drug,
l) the person engages in or has engaged in anti-social behaviour,
m) the person has a particular economic or social status or is a member of a particular culture or racial group.

2) Nothing in this Part prevents, in relation to a person who takes or has taken alcohol or any other drug, the serious or permanent physiological, biochemical or psychological effects of drug taking from being regarded as an indication that a person is suffering from mental illness or other condition of disability of mind.

The intention of section 16 is to ensure that a person whose beliefs or behaviour might be considered socially unacceptable or generally not tolerated is not a mentally ill person and therefore cannot be involuntarily detained in a hospital. It should be noted, however, that section 16(2) does provide that a person who suffers a psychiatric illness as a result of long-term drug or alcohol intake can be deemed to have a mental illness within the meaning of the Act.

ADMISSION TO AND DETENTION IN A MENTAL HEALTH FACILITY UNDER THE NEW SOUTH WALES ACT

The New South Wales Act does not refer to the term 'psychiatric hospital' but uses the terminology of 'mental health facility' or 'declared mental health facility'.

Declared mental health facility

A declared mental health facility means premises subject to an order in force under section 109 of the Act. Reference in the Act to a mental health facility includes a declared mental health facility or a private mental health facility.

In essence, declared mental health facilities are those premises that have been gazetted by order of, or granted a licence by, the Director General of Health to admit, care and treat persons who come under the provisions of the *Mental Health Act*.

Admission to a declared mental health facility

Persons admitted to a mental health facility in New South Wales fall under one of two categories, namely, voluntary or involuntary.

ADMISSION OF A PERSON AS A VOLUNTARY PATIENT

Voluntary patients are those patients who are admitted to a mental health facility at their own request and may leave when they want to or when they are well enough

to be discharged. The Act makes provision for the process to be followed for admission and discharge of a person as a voluntary patient (ss 5–8 inclusive). The particular provision for a person over 16 years to admit himself or herself as an involuntary patient is relatively straightforward, subject to the provision that an authorised medical officer needs to be satisfied that the person is likely to benefit from care and treatment in a mental health facility (s 5). Care has to be taken, however, in the admission of persons under 16 years of age and those persons who are under guardianship within the *Guardianship Act 1987*.

A person under guardianship within the meaning of the *Guardianship Act* may be admitted to a mental health facility as a voluntary patient following a request made by the person's guardian to the authorised medical officer (s 7).

If a person under the age of 16 years is admitted to a mental health facility as a voluntary patient, the authorised medical officer must, as soon as practicable after admission, do all that is reasonably practicable to notify the person's parents of the person's admission (s 6).

If a parent of a person 14 or 15 years of age who has been admitted to a mental health facility as a voluntary patient objects to the person receiving care or treatment at the mental health facility, the authorised medical officer must discharge the person unless he or she elects to continue as a voluntary patient (s 6).

A person under the age of 14 years must not be admitted to a mental health facility as a voluntary patient if a parent of the person has notified the authorised medical officer that he or she objects to the person being admitted (s 6).

If a parent of a person under the age of 14 years who has been admitted to a mental health facility as a voluntary patient notifies the authorised medical officer that he or she objects to the person receiving care or treatment at the mental health facility, the authorised medical officer must discharge the person (s 6).

A person under guardianship must not be admitted to a mental health facility as a voluntary patient if, at or before the time at which the person seeks to be admitted, the guardian of the person has notified the authorised medical officer that he or she objects to the person being admitted (s 7).

If the guardian of a person who has been admitted to a mental health facility as a voluntary patient notifies the authorised medical officer that he or she objects to the person receiving care or treatment at the mental health facility, the authorised medical officer must discharge the person (s 7).

A person who requests and is refused admission as a voluntary patient or who believes they have been inappropriately discharged may seek a review of that decision in accordance with the provisions of section 11. This is not a formal appeal mechanism but simply a provision requiring the medical superintendent to review the decision of another medical officer.

Review of care and discharge of voluntary patients

A voluntary patient may discharge themselves at any time. As well, an authorised medical officer may do so if they decide that the patient is unlikely to benefit from any further inpatient care and treatment. Where the patient is under guardianship, notice of the discharge must be given to the person's guardian (ss 7 and 8).

If a voluntary patient should remain in a mental health facility for a continuous period in excess of 12 months, their case must be brought to the attention of the Mental Health Review Tribunal by the medical superintendent and the tribunal must review the case (see the section below titled 'What is the Mental Health Review Tribunal?'). In undertaking that review and as considered appropriate, the tribunal may order the discharge of the patient but may defer the discharge for a period not exceeding 14 days, or make no order at all, thereby continuing the patient's care and treatment as a voluntary patient (s 8).

ADMISSION OF INVOLUNTARY PATIENTS

An involuntary patient is a person who is admitted and detained in a mental health facility for the purposes of receiving care, treatment and control either against the person's wishes or on the request of a specified other person or a court order. A person may be admitted and detained as an involuntary patient either on the grounds that the person is a mentally ill person or a mentally disordered person as defined in the Act.

Regardless of whether the person is mentally ill or mentally disordered, admission of an involuntary patient to a hospital for care and treatment can be done in one of the following ways:

- on the certificate of a medical practitioner or accredited person (s 19);
- on the information of an ambulance officer (s 20);
- after apprehension by police (s 22);
- following an order for medical examination (s 23);
- on order of the court (s 24);
- on transfer from another health facility (s 25);
- on request of the primary carer, relative or friend (s 26).

On the certificate of a medical practitioner or accredited person (s 19)

A person may be taken to and detained in a declared mental health facility on the certificate of a medical practitioner or an accredited person who has examined the person and formed the opinion that the person is either mentally ill or mentally disordered. The certificate is to be in the form as set out in Schedule 1 of the Act. The certificate is valid for 5 days for a mentally ill person and one day for a mentally disordered person.

An accredited person is defined in section 136 of the Act as any person appointed by the Director General as such. The phrase 'accredited person' has been described as 'a suitably qualified and experienced mental health practitioner, such as a nurse, psychologist or social worker, who is specifically empowered to write Schedule 1 certificates, usually in areas where there are insufficient doctors'.[4]

On the information of an ambulance officer (s 20)

An ambulance officer may take a person to a defined mental health facility if the officer believes on reasonable grounds that the person appears mentally ill or mentally disturbed and that it would be beneficial for the person to do so. In doing so,

an ambulance officer may request police assistance. Where such a request is made, a police officer may enter premises and apprehend the person without a warrant (s 21). As well, in transporting a person to or from a mental health facility, a police officer may use reasonable force and may restrain the person in any way that is considered reasonably necessary (s 81).

After apprehension by police (s 22)

The police may apprehend and take a person to a declared mental health facility if they have found the person in a public place and are of the opinion that the person is mentally ill or mentally disturbed *and* the police believe the person has recently attempted to kill himself or herself or will try to do so, or will attempt to cause serious bodily harm to himself or herself, or is committing or has recently committed an offence and the police believe it would benefit the welfare of the person to be dealt with under mental health law rather than criminal law.

Following an order for medical examination (s 23)

If a magistrate or registrar of the court is satisfied, by evidence on oath, that a person may be a mentally ill person or a mentally disordered person, and that because of physical inaccessibility the person could not be personally examined, the magistrate or registrar may, by order, authorise a medical practitioner or accredited person as well as any other persons (including a member of the police force) who may be required to assist the medical practitioner or accredited person to visit and to personally examine or observe the person. Those persons authorised to visit or observe may enter the premises, if need be by force, to enable the examination or observation to be carried out.

In many cases, particularly in country areas, a person may be admitted to the local hospital in the first instance for immediate assessment, care and control. The local medical practitioner will then complete a certificate in accordance with Schedule 1 of the Act that, in his or her opinion, the person is mentally ill or mentally disordered and should be detained. It is then necessary for the person to be transferred to a declared mental health facility for assessment and, if considered necessary in accordance with the Act, care and detention for a specified period of time.

On order of the court (s 24)

A person may be taken to and detained in a declared mental health facility in accordance with an order made under section 33 of the *Mental Health (Forensic Provisions) Act 1990*. Where the magistrate is of the opinion that the person appearing before him or her in relation to a criminal matter is a mentally ill person, he or she may order the person to be taken to a declared mental health facility for assessment.

On transfer from another health facility (s 25)

A person may be transferred from a hospital or health facility to a declared mental health facility if a medical officer of the hospital or health facility considers the person to be mentally ill or mentally disordered and should be detained. In those circumstances the person will be deemed to have been detained pursuant to the provisions of section 19 of the Act.

On request of the primary carer, relative or friend (s 26)

A person may be detained in a declared mental health facility on a written request made by the primary carer, relative or friend of the person to an authorised medical officer. The medical officer must not detain any such person unless he or she is satisfied that, because of the distances required to be travelled in order to have the person examined by a medical practitioner and the urgency of the circumstances, it is not reasonably practicable to have the person detained by a mental health certificate.

The appointment, and role, of the person nominated as a primary carer under the Act is elaborated upon later in this chapter.

Examination requirements at the declared mental health facility (s 27)

Once a person has been brought to the declared mental health facility for admission in accordance with one or other of the above procedures, specific provisions in the Act set out the steps which must then be followed. The provisions require a number of examinations to be undertaken. A medical practitioner on whose certificate or request a person has been admitted to a mental health facility may not conduct any of these examinations.

The first examination must be conducted by an authorised medical officer and must occur as soon as practicable and not more than 12 hours after the person's arrival. If the person is found to be mentally ill or mentally disordered, they must be seen by a second medical officer. If not found to be mentally ill or mentally disordered, the person must be discharged (s 27(a)).

If a second examination is required, it must be conducted 'as soon as practicable' by a psychiatrist (unless the first examination was conducted by a psychiatrist). If one of the examining medical officers concludes that the person is mentally ill the person must be reviewed by an inquiry conducted by the Mental Health Review Tribunal (the tribunal). If both medical officers find the person is mentally disordered the person may be detained for up to 3 days (not including weekends or public holidays). Where the second medical officer finds the person is neither mentally ill nor mentally disordered, the person must be examined for a third time (s 27(b)).

The third examination must be conducted as soon as practicable by a psychiatrist. The provision 'as soon as practicable' may depend on the location and availability of another psychiatrist. Ultimately, the finding made by the third medical officer will determine whether the person is detained as a mentally ill or mentally disordered person or is discharged (s 27(c)). Before the third examination and if the authorised medical officer considers it clinically appropriate, the person may be admitted as a voluntary patient or discharged on the basis that 'care of a less restrictive kind' is available. On that latter point, it is important to always bear in mind the provisions of section 12 already referred to — that is, that a person must not be admitted and detained in hospital unless the authorised medical officer is of the opinion that the person is mentally ill or mentally disordered *and* no other care of a less restrictive kind is appropriate and reasonably available to the person.

If a person is found to be mentally ill after initial examinations have occurred and that finding is to be the subject of review by the tribunal, minimum medication is to be prescribed for the person consistent with proper care to ensure that the

person can communicate adequately with anyone who may be engaged to represent the person at any subsequent mental health inquiry before the tribunal (s 29).

Once a person is detained either as a mentally ill or a mentally disordered person, they are to be given a written statement of their legal rights as well as an oral explanation of them. Obviously, if the person does not understand English, steps must be taken to have those rights given to the person in a language he or she understands (s 74).

If a person brought in by the police is found not to be mentally ill or mentally disordered the mental health facility may detain the person for 1 hour to enable the police to attend and take the person into their custody. If the police do not wish to take custody of the person the mental health facility may discharge the person into the care of a relative or friend or admit the person as a voluntary patient (s 32).

Where a person has been brought to a mental health facility for assessment (generally by the police or some other relevant person) pursuant to an order under section 33(1)(b) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) and is found not to be mentally ill or mentally disordered, the person is to be released into the custody of the police or the relevant person who brought the person to the mental health facility as soon as practicable (s 32).

NOMINATION OF PRIMARY CARER BY A PERSON ADMITTED AS A VOLUNTARY PATIENT, OR DETAINED AS AN INVOLUNTARY PATIENT, 'ASSESSABLE PERSON' OR SUBJECT TO A COMMUNITY TREATMENT ORDER UNDER THE ACT

One of the major changes introduced into the *Mental Health Act 2007* (NSW) recognises the role and participation of the 'primary carer' in relation to treatment decisions and plans made in relation to voluntary or involuntary patients, an 'assessable person' under the Act or a person subject to a community treatment order. An 'assessable person' is a person detained in a mental health facility where a tribunal inquiry is to be held (s 17).

A primary carer for the purposes of the Act, as set out in section 71, can be:

- a person who has been appointed the patient's guardian under the *Guardianship Act 1987*; or
- the parent of a child; or

if the patient does not fit into the above categories:

- where a child is aged over 14 years and is not under guardianship, the person nominated by the patient as the primary carer; or
- the patient's spouse or partner where the relationship is close and continuing (this includes de facto and same sex partners); or
- a close friend or relative of the patient; or
- someone who is primarily responsible for providing support and care (though not on a wholly or substantially commercial basis) — a person in receipt of a Carer's Pension is not seen as providing care on a commercial basis and can therefore be considered as a primary carer.[5]

Section 72 outlines the steps to be followed in nominating a primary carer. A patient who does not have a guardian and is over 14 can nominate a carer at any time. Once a person has been nominated and accepted as a primary carer, the nomination stays in force for 12 months but may be revoked at any time. Patients may also nominate persons who they wish to exclude from receiving information about them or nominate information they wish their primary carer to be excluded from receiving, except, where the patient is between 14 and 18 years, their parents may not be excluded from receiving information about their care and treatment.

Once a patient has nominated a person to be their primary carer, the authorised medical officer or director of community treatment must put it into effect, unless there are reasonable grounds for them to believe that to proceed with the nomination, the patient, the carer or any other person may be at risk of serious harm or that the patient was incapable of making the nomination.

The Act provides that an authorised medical officer must take all reasonably practicable steps to notify the primary carer (unless otherwise excluded) of:

- within the first 24 hours of detention (unless the patient is a voluntary patient), the patient's detention in a mental health facility (s 75);
- a scheduled mental health inquiry (s 76);
- any unauthorised absence from a mental health facility (s 78(1)(a));
- any proposed transfer between mental health facilities (s 78(1)(b));
- the patient's discharge or reclassification as a voluntary patient (s 78(1)(c) and (d));
- any application to the Mental Health Review Tribunal for electroconvulsive therapy, urgent surgical operations or special medical treatment (s 78(1)(e), (f) and (g)).

A person nominated as a primary carer has the right to make certain requests under the Act and to be involved in the patient's discharge planning. As noted earlier, a primary carer may request a person's admission to a mental health facility under section 26. As well, a primary carer is entitled to request information about the type of medication being administered to the patient (s 73) and may request that the patient be discharged into their care, provided they give an undertaking that the patient will be properly cared for and the authorised medical officer is satisfied that such a step is appropriate and would not cause harm to either the patient, the primary carer or others (s 43). If the authorised medical officer refuses the primary carer's request for the patient to be discharged into their care, the primary carer may appeal to the tribunal (s 44).

A primary carer is one of the categories of persons who may apply to the tribunal for a community treatment order under section 51 of the Act. As well, a primary carer may advise the medical superintendent of a mental health facility that the patient has requested a visit from an official visitor. When such a request is received, the medical superintendent must arrange a visit within two working days (s 134). When a patient is being discharged, his or her primary carer should be consulted in relation to any follow-up care and treatment proposed (s 79).

LIMITED DETENTION OF A MENTALLY DISORDERED PERSON

Section 31 outlines the relevant detention provisions applying to a person found to be mentally disordered, summarised as follows:

- a mentally disordered person must not be detained for a continuous period in excess of 3 days (not including weekends and public holidays);
- the person must be examined at least once every 24 hours by the authorised medical officer;
- the person must not be detained if, following such examination, the authorised medical officer believes the person is not mentally disordered or mentally ill or that care of a less restrictive kind is appropriate and available;
- a person must not be admitted or detained as a mentally disordered person on more than three occasions in any one month.

DETENTION OF A MENTALLY ILL PERSON

If a person is found to be mentally ill following admission to a mental health facility, he or she is then known as an 'assessable person' subject to an inquiry by the tribunal. The purpose of the tribunal's inquiry is to inquire into and confirm or overrule the initial decision that the person is mentally ill and decide the subsequent period of detention and care to be given.

Steps must be taken to bring the person before the tribunal 'as soon as practicable' (s 27(d)). Specific legislative provisions must be followed preparatory to bringing a person before a tribunal inquiry. A summary of these legislative provisions follows.[6]

Once a person has been admitted and detained as an 'assessable person' the mental health facility must notify the person's primary carer of the tribunal inquiry (s 76). As well, the person must be given an explanation about the proposed inquiry in a language he or she can understand (s 74). The person must be given a clear explanation of their rights as well as an explanation of the order the mental health facility will be seeking from the tribunal inquiry. The person is entitled to have the opportunity to ask questions about the inquiry process. If need be, a competent interpreter should be arranged and be present to assist as required. The person is entitled to independent legal representation at the inquiry and, where appropriate, that should also be organised. Steps should be taken to ensure the person has the opportunity to talk with their legal representative in an appropriate place that affords them privacy and confidentiality.

The Act requires that, where reasonably practicable, the person appears in street clothes for the inquiry hearing (s 34) and that steps are taken to ensure the minimum of medication, consistent with proper care, is prescribed, to ensure the person is able to communicate adequately with their legal representative before the inquiry hearing (s 29).

The mental health facility must make arrangements as necessary to ensure that appropriate medical witnesses appear and all relevant medical records are made available for the hearing (s 34).

The inquiry before the tribunal should be conducted in such a way so as to ensure the person is afforded every possible assistance as well as independent and proper legal representation. If the tribunal is not satisfied that due notice has been given

to the person and their primary carer about the inquiry or that the person has not been informed of his or her legal rights, the tribunal can adjourn the inquiry for a period not exceeding 14 days (s 36). The tribunal may also adjourn an inquiry for 14 days if it is considered in the best interests of the person, having regard to the documentation before it (s 36). When that occurs, the person will continue to be detained.

Before commencing the inquiry, the tribunal is required to ensure that the provisions of the *Mental Health Act* required to be complied with before an inquiry is conducted have been satisfied — the tribunal will check the person's accompanying documentation to ensure it has the jurisdiction to conduct the inquiry. The tribunal must also ensure that the person appearing before them has been given a Statement of Rights, that proper notice has been given to the person and primary carer about the inquiry and ensure legal representation is present if required as well as an interpreter. Inquiries should be made into the person's medication, taking into account any effect that may have on the person's ability to communicate and the tribunal must take into account any cultural factors that may be relevant to the question of mental illness (s 35).

After hearing from all parties represented at the inquiry, the tribunal is required to determine, on the balance of probabilities, whether or not the person is mentally ill; that is, the tribunal considers whether it is more likely than not that the person is mentally ill.[7]

Once the tribunal comes to the decision that the person is a mentally ill person, the following care provisions are available for the tribunal to consider (s 35):

- discharge the person into the care of their primary carer; *or*
- discharge the patient on a community treatment order of not more than 12 months; *or*
- make an involuntary patient order directing that the person be detained for a period not exceeding three months.

Conversely, if after hearing the evidence the tribunal is not satisfied that the person is a mentally ill person, the following options are available for the tribunal to consider (s 35):

- discharge the person; *or*
- discharge the patient but defer the discharge for a period not exceeding 14 days if it is considered in the person's best interests.

Once the tribunal has made an involuntary patient order to detain the person, it must consider the person's capacity to manage their financial affairs. If it is considered the person is not capable of managing their affairs, it must make an order for financial management under section 44 of the *Trustee and Guardian Act 2009* (NSW). Such an order can be revoked by the tribunal at a later time if the person is discharged and the tribunal is satisfied the person can manage their own financial affairs (*Trustee and Guardian Act* s 88).[8]

It is possible of course that a mentally ill person who is subject to an inquiry by the tribunal may elect to remain in the mental health facility for care and treatment.

If so, he or she would be admitted as a voluntary patient, and the relevant provisions of the *Mental Health Act 2007* would apply.

If the tribunal decides to make an involuntary treatment order in relation to a person who appears before it to the effect that the person be detained as an involuntary patient for a specified period of time not exceeding 3 months, the person must first be advised of their right of appeal against the tribunal's finding. In the first instance, the person can request the authorised medical officer to discharge him or her. If that request is refused, the person can appeal to a three-member tribunal panel (s 44). As well, the person's primary carer may apply to the authorised medical officer for the person to be discharged into their care. That request may be granted subject to the primary carer's giving a written undertaking that the person will be properly cared for and the medical officer's being satisfied of the safety of the person, the carer and others (s 43).

What is the Mental Health Review Tribunal?

The tribunal is a quasi-judicial body. Its role is to make and review orders and be an independent review and appeal body in relation to the determination and treatment of mentally ill persons both at civil and criminal law. The tribunal conducts hearings in person or by video conference or telephone in mental health facilities or community healthcare centres in metropolitan and regional New South Wales.

THE COMPOSITION OF THE TRIBUNAL

The composition of the tribunal members is drawn from:

- Australian lawyers;
- psychiatrists;
- persons having, in the opinion of the State Governor, other suitable qualifications or experience, including at least one person selected from a group of persons who are nominated by consumer organisations.

The section also provides that the members of the tribunal must include one woman (or more) and one or more persons of ethnic background (s 141).

The tribunal generally sits as a panel of three members except when it is conducting an initial mental health inquiry when one legal member sits alone. The tribunal may also sit as a one-person panel when handling certain routine matters such as an uncontested variation of a community treatment order. A three-member tribunal panel consists of a lawyer who chairs the panel, a psychiatrist and another suitably qualified member.

The tribunal is required to sit as a panel of three members when it undertakes:

- reviews of involuntary patients;
- annual reviews of voluntary patients;
- appeals against refusal to discharge;
- applications for community treatment orders;
- applications for electroconvulsive therapy, surgical operations and special medical treatment.

THE ROLE OF THE TRIBUNAL

The tribunal's role extends across hearings in relation to mentally ill and mentally disordered persons including those persons who commit a criminal offence where their state of mental health at the time of committing the offence is a critical factor in determining how they are to be dealt with by the legal system. Such persons are known as forensic patients. All other persons who come before the tribunal are referred to as civil patients.

The tribunal's role in dealing with civil patients encompasses:

- conducting mental health inquiries and making Involuntary Patient Orders authorising the continued involuntary detention of a person in a mental health facility;
- reviewing involuntary patients in mental health facilities, usually every 3 or 6 months, and in appropriate cases every 12 months;
- reviewing voluntary patients in mental health facilities, usually every 12 months;
- hearing appeals against an authorised medical officer's refusal to discharge an involuntary patient;
- making, varying or revoking community treatment orders;
- approving the use of electroconvulsive therapy (ECT) for involuntary patients;
- determining if voluntary patients have consented to ECT;
- approving surgery for an involuntary patient detained in a mental health facility;
- approving special medical treatment (sterilisation) for involuntary patients; and
- making and revoking orders under the *Trustee and Guardian Act 2009* (NSW) for a person's financial affairs to be managed by the NSW Trustee.

As well, the tribunal reviews all forensic patients who:

- have been found not guilty by a court by reason of mental illness;
- have been found unfit to be tried by reason of mental illness; or
- have been transferred from prison to hospital because of mental illness.

THE PROCEDURE OF THE TRIBUNAL

The *Mental Health Act* quite specifically provides that the proceedings of the tribunal are to be conducted 'with as little formality and technicality, and with as much expedition … as the proper consideration of the matters before the Tribunal permit' (s 151). The tribunal is not bound by the rules of evidence (s 151) and may call upon any person it considers relevant to assist in any matter to be determined (s 154).

The Act goes to considerable lengths to ensure that the proceedings of the tribunal are fair, open and proper in every respect. Accordingly, the Act provides as follows:

- in general, the proceedings of the tribunal are open to the public but the tribunal may order otherwise;

- patients may be represented before the tribunal by a legal practitioner or by another person, with the approval of the tribunal (s 154);
- interpreters must be provided where appropriate (s 158);
- a person having any matter before the tribunal shall be entitled to inspect and have access to his or her medical records, unless the tribunal determines otherwise; a representative of the person is also entitled to access the medical records (s 156);
- the tribunal has power to issue a summons requiring the personal attendance of a witness at the tribunal and/or the production of documents either of its own motion or on the application of the person the subject of the inquiry or his or her representative (s 157);
- the proceedings of the tribunal are sound-recorded and every decision of the tribunal must be reduced to writing and signed by the chairperson (s 159) — this is important, because the Act provides for an extensive ground of appeal to the Supreme Court for the benefit of the person who is the subject of the tribunal's determination.

APPEALS FROM DECISIONS OF THE TRIBUNAL

Appeals against a determination of the tribunal made with respect to a person or the failure or refusal of the tribunal to make an order with respect to the person may be made to the Supreme Court of New South Wales (s 163).

Forms and types of treatment under the Act

In the main, persons who are deemed to be mentally ill or mentally disordered, either as a voluntary or involuntary patient, will be treated with a variety of therapeutic medications together with counselling, rehabilitation and social support services. Such treatment may occur in a variety of settings. The emphasis in New South Wales is, as already mentioned, to use detention for the purposes of care, treatment and control only as a last resort. In order to facilitate that approach, provision has been made in the Act for a 'community treatment order' to be made. The very title of such an order confirms it is designed to be implemented in a community healthcare setting and not in an institutional environment.

COMMUNITY TREATMENT ORDERS

A community treatment order (CTO) is an order made by the Mental Health Review Tribunal that compels a person to visit a community mental health facility or be at a specified place at certain times to receive treatment as contained in the treatment plan that is an integral part of a CTO.

An application to the tribunal for a CTO in relation to a person may be made by the authorised medical officer of a mental health facility in which the person is detained or is a patient, a medical officer familiar with the clinical history of the person, the person's primary carer, or a director of a community mental health facility familiar with the person's clinical history (s 51). Before the application is made, however, it will be necessary to liaise with the community mental health

facility that is going to be responsible for drawing up and implementing the treatment plan that must accompany the application for the CTO.

A CTO may be made in relation to a person detained in a mental health facility or a person living in the community and it may also be made if a person is already subject to a current CTO (s 51).

A CTO may be made by the tribunal following a mental health inquiry where the person is found to be mentally ill and a CTO is seen as the least restrictive alternative consistent with safe and effective care. As well, a CTO may be made on a review of a patient by the tribunal or following an application to the tribunal (s 51). The maximum period for a CTO is 12 months (s 53(6)). However, section 67 of the Act provides an automatic right of appeal if a CTO is made for longer than 6 months or no duration is specified. For that reason most CTOs will continue to be for 6 months.

In deciding to approve a CTO the tribunal is required to consider the following provisions of section 53:[9]

- Has an appropriate treatment plan been drawn up by the community mental health facility?
- Will the person benefit from a CTO as the least restrictive alternative consistent with safe and effective care?
- Is the community mental health facility capable of implementing the plan?
- Does the person have a prior diagnosis of a mental illness, and if so, is there a previous history of refusing to accept appropriate treatment?

In making a CTO, a treatment plan must accompany it. A treatment plan is usually prepared by the person's psychiatric case manager and forms part of the CTO application for the tribunal's approval. A prepared treatment plan should nominate the mental health facility that is to implement the plan as well as requiring the affected person to be present at the specified times and places to receive medication, therapy, counselling, management, rehabilitation and other services according to the plan (s 56). As well, a treatment plan must specify the place, time and method by which the services will be provided (s 54).

If the person who is to be the subject of a CTO is not detained in a mental health facility at the time the application is to be made, the person must be given 14 days' written notice of the CTO application to be made as well as a copy of the treatment plan to accompany the application (s 52).

The tribunal may vary or revoke a CTO (s 65). Such an application would normally be made if there was a change of circumstances affecting the person, for example, a change in the person's medication as part of the treatment plan. An application to vary or revoke can be made by any of the persons or parties who are able to make an application for a CTO in the first place (as mentioned earlier in this chapter).

If the person who is the subject of a CTO fails or refuses to comply with its conditions, steps can be taken to initiate breach proceedings (s 58). In the first instance the director of the mental health facility must assess the situation and consider if all reasonable steps have been taken to implement the CTO as well as

the person's overall mental health. If considered appropriate, a verbal warning may be given to the person that a continued failure by them to comply with the CTO may result in their being compulsorily taken to a mental health facility and treated against their will. If there is still no cooperation from the person, a written breach notice may be issued requiring the person to attend the mental health facility for treatment. If need be, police assistance may be requested to apprehend the person and bring them to the relevant mental health facility (s 59). If a person is admitted to a mental health facility as a result of breaching a CTO, an authorised medical officer must review the person's mental health condition within 12 hours of arrival and may detain the person at the facility following the review and give them treatment (s 61).

The person who is the subject of a CTO may appeal. Where the appeal is heard will depend on who made the order in the first instance. If a CTO was made by a single-member panel of the tribunal, the appeal would lie to a three-member panel. However, if a three-member panel was the body that made the CTO, the appeal would lie to the Supreme Court of New South Wales. Appeals to the Supreme Court can be on the basis of any question of law or fact arising from the order as well as any CTO made in excess of 6 months or for an indeterminate period (s 67).

ELECTROCONVULSIVE THERAPY (ECT)

The *Mental Health Act 2007* (NSW) makes provision for ECT and the conditions which are required to apply to any person in New South Wales for whom ECT is proposed.

Who can administer ECT?

Two medical practitioners must be present — one experienced in administering ECT, the other experienced in administering anaesthesia (s 181).

The procedure for giving ECT to a voluntary patient

ECT may be given to a voluntary patient once their informed and freely given consent has been obtained (s 91). The voluntary patient must have been given the following information, as set out in section 91:

- a fair explanation of the procedure;
- a full description of the possible discomforts and risks, including the possible loss of memory;
- information about alternative treatments;
- a full description of the expected benefits;
- notice that at any time consent can be withdrawn and the procedure discontinued;
- a full disclosure of any financial relationship between those proposing the treatment and those administering the treatment;
- notice of the right to obtain legal and medical advice and to be represented before giving consent;

- any question relating to the procedure being answered in terms they appear to have understood;
- the person must not be on medication that significantly impairs their ability to give consent (s 92).

Two medical practitioners (one of whom must be a psychiatrist) must certify, in writing, after considering the person's clinical condition, history of treatment and any appropriate alternative treatments, that ECT is a reasonable and proper treatment for the person to have in all the circumstances and that it is necessary or desirable for the safety or welfare of the person (s 93).

It is important to remember that voluntary patients cannot be given ECT without their written informed consent. If the voluntary patient lacks the capacity to consent, no other person may consent on their behalf; for example, parents cannot consent on behalf of a child who lacks the capacity to consent, or refuses to give their informed consent. Where an authorised medical officer is unsure whether a voluntary patient is capable of giving informed consent, an application must be made to the tribunal and notice given to the patient's primary carer of that application. When dealing with the matter the tribunal's role is to determine whether the patient is capable of giving informed consent and whether or not they have actually given their consent as required (s 96(1)). If the tribunal determines the patient lacks capacity or has refused treatment, ECT cannot be administered whilsoever the patient remains a voluntary patient.[10]

The procedure for giving ECT to an involuntary patient and persons detained in a mental health facility

Where two medical practitioners (one of whom is a psychiatrist) certify that ECT is a reasonable and proper treatment in all the circumstances and is necessary or desirable for the safety or welfare of the patient (s 94), an authorised medical officer must apply to the tribunal for permission to administer ECT to an involuntary patient or any other person detained in a mental health facility. Such an application may be made where the person has been detained as an assessable person, the person is subject to an adjournment made at a mental health inquiry, or the person is subject to an involuntary patient order made by the tribunal.[11]

The tribunal's inquiry

When an application is made, the tribunal must hold an inquiry as soon as practicable to determine whether or not the application for ECT should be granted (s 95). As always, the tribunal must, at the outset, ensure that the patient's primary carer has been given notice of the application. The patient must be informed about the purpose of the application and what the possible outcome of the inquiry could be. As well as the medical evidence given to the tribunal in support of the application, the tribunal must take into account the views expressed by the patient, and the effect that any medication administered to the patient may have had on the patient's ability to communicate with the tribunal.

If the tribunal is satisfied that the patient is capable of giving informed consent and has given that consent *or* there is no informed consent but the treatment is

necessary or desirable for the safety or welfare of the patient, ECT can be administered (s 96(3)).

Maximum number of treatments and duration of an ECT order

The maximum number of ECT treatments the tribunal may order must not exceed 12 except in special circumstances (s 96(4) and (5)). When an order for ECT is made, it is valid for 6 months unless a shorter period is specified *or* until the patient is no longer an involuntary or detained patient.

Register of ECT

Wherever ECT is administered, a register (in a prescribed form) must be kept (s 97).

SURGERY OR SPECIAL MEDICAL TREATMENT

Surgical operation

Section 98 of the Act defines a 'surgical operation' as any surgical procedure, a series of related surgical operations or surgical procedures, and the administration of an anaesthetic for the purposes of medical investigation.

Where a condition arises requiring surgical intervention, a voluntary patient is generally capable of consenting to whatever procedure is necessary; for example, an appendicectomy or repair of an inguinal hernia. However, if it is an emergency and, for whatever reason, a voluntary patient is not able to give informed consent, the Director General of Health or the tribunal may give consent on their behalf if it is considered necessary, as a matter of urgency, to save life or prevent serious harm to the patient.

In relation to an involuntary patient, non-emergency surgery can be undertaken if the patient is able to give informed consent. Where that is not possible, the patient's primary carer is to be advised in writing and permission requested — giving a maximum of 14 days to allow the primary carer to reply. If the primary carer agrees, the Director General of Health must consent as long as he or she is satisfied that informed consent cannot be obtained from the patient and that the surgery is necessary and in the patient's best interests (s 100). Before the 14 days have elapsed and if an authorised medical officer considers the situation to be urgent *or* the primary carer has indicated they have no objection, an application may be made to the Director General for permission to proceed with the proposed surgery.

If the primary carer does not agree to the proposed surgery or cannot be located, an authorised medical officer may apply to the tribunal for permission (s 101). The tribunal can consent if satisfied that informed consent cannot be obtained from the patient and the proposed surgery is in the patient's best interests. In an emergency, the tribunal may consider an application to proceed within the 14-day period if it is satisfied the matter is urgent *or* the primary carer does not object.

Special medical treatment

Section 98 defines 'special medical treatment' as any treatment, procedure, operation or examination that is carried out on a person that is intended, or is reasonably likely, to have the effect of rendering the person infertile.

Special medical treatment is not to be undertaken on an involuntary patient unless it is necessary, as a matter of urgency, to save the patient's life or prevent serious damage to the patient's health *or* consent has been given by the tribunal (s 102). The tribunal may consent to the procedure if satisfied it is necessary to prevent serious damage to the patient's health and the patient is over 16 years of age. The patient's primary carer must be notified by the authorised medical officer of the intended application to the tribunal and allow 14 days to elapse before the application is made unless the authorised medical officer considers the circumstances urgent *or* the primary carer agrees (s 103).

Specific treatments prohibited under the Act

Section 83 of the Act specifically prohibits a person administering to or performing on another person psychosurgery, deep sleep therapy or insulin coma therapy.

PATIENT RIGHTS, REVIEW OF CARE AND APPEAL MECHANISMS UNDER THE ACT

Patient rights

The New South Wales Act goes to great lengths to affirm the fundamental rights of a person brought within the provisions of the Act by reason of being a mentally ill or mentally disordered person. Probably the most important of those rights is the right to give and withhold consent to treatment. Unless the Act specifically provides otherwise, every person, whether they are a voluntary (informal) or involuntary patient under the Act, retains the right to give or withhold consent to treatment. At the same time there is a clear bias in the Act towards community care and treatment and away from involuntary detention except as a last resort. The Act provides a number of quite definitive statements designed to reinforce a person's rights and individual dignity in a number of ways and the importance of involving the person in decisions about their care and treatment as much as possible. As set out earlier in this chapter, section 3 identifies the objects of the Act in a manner consistent with providing the best possible healthcare for the mentally ill or mentally disordered in the least restrictive environment while protecting their rights as consumers of healthcare.

As well, section 68 sets out the key principles that should underpin the care and treatment of persons with a mental illness or mental disorder. For example, section 68(h) specifically provides that, where practicable, patients should be involved in treatment decisions and plans for their care. Patient involvement is further mentioned in section 79, which requires an authorised medical officer of a mental health facility to take steps to involve the patient and primary carer in patient discharge discussions.

The overall objectives of the public health system in the provision of mental health services are also provided in section 105. Those objectives provide for the public health system to establish, develop, promote, assist and encourage mental health services that ensure the highest possible standards of mental healthcare with emphasis on that care to be comprehensive and accessible and located in the community wherever possible. Finally, the Act also acknowledges the role of patient participation by including a patient Statement of Rights in Schedule 3. The

fundamental rights guaranteed for persons dealt with under the Act can be summarised as follows:

- the right to be informed;
- the right to the least restrictive environment;
- the right to an independent review of decisions made about detention and treatment;
- the right of appeal mechanisms.

REVIEW OF CARE

The Act provides ongoing mechanisms for the review of standards of care in both mental health facilities and associated centres overseeing community care, treatment and orders under the Act. In New South Wales this function is undertaken by persons designated as official visitors and authorised officers.

Authorised officers

Authorised officers are appointed by the Director General of Health (s 137). Their task is to visit and inspect mental health facilities and conduct investigations about care, treatment or control of persons in mental health facilities. They have wide-ranging powers of inquiry and may request the production of books, documents and records and may cross-examine employees under oath. A failure to comply with any requests made by an authorised officer without reasonable excuse may result in a financial penalty (s 138). Also, in conducting their investigations authorised officers may obtain information from employees of the facility but the information obtained cannot be used against the employee if the employee objects that the giving of such information may incriminate him or her (s 139).

Official visitors

Official visitors are appointed by the Minister for Health and required to visit mental health facilities and community mental health facilities and units at least once every month. They may or may not give notice of their intention to do so. The role of official visitors is to be available to speak with patients or primary carers who have the right to bring to the attention of the official visitor any matter they are unhappy about in relation to care and treatment. Official visitors are also able and indeed required to inspect premises and examine patient records and cannot be prevented from inspecting any part of a mental health facility or community mental health facility. A patient and primary carer must be advised of their right of access to an official visitor and, if they request to speak with one, the mental health facility is obliged to pass on that request within 2 working days. Official visitors usually report to a person appointed as the principal official visitor who in turn reports to the Minister for Health on a regular basis but they may report directly to the minister if the matter is sufficiently urgent (ss 128–135 inclusive).

Specific standards regarding medication

Section 85 of the Act provides that a medical practitioner must not administer or cause to be administered to a person a dosage of drugs which, having regard to

proper professional standards, is excessive or inappropriate, in relation to any mental illness or condition from which the person is or is suspected to be suffering.

Usage of medication to be reviewed

Section 86 of the Act provides that the medical superintendent or community director of a mental health facility is to establish and maintain an internal review system to monitor and review the prescription and use of drugs within the mental health facility in terms of frequency of administration, dosage, intended and unintended effects, and appropriateness of use.

Northern Territory: *Mental Health and Related Services Act 1998*

OBJECTIVES AND DEFINITIONS

The objectives of the Act are set out in comprehensive detail in section 3. They embody a commitment to the proper care, treatment and protection of people with mental illness while protecting their civil rights.

Generally, the relevant definitions for the purposes of the Act are set out in full in section 4, although some of the more significant definitions are given separately. For example, the definition of 'mental illness' is separately defined in section 6 as follows:

> 1) In this Act, 'mental illness' means a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person in one or more of the areas of thought, mood, volition, perception, orientation or memory and is characterised:
>
> a) by the presence of at least one of the following symptoms:
>
> i) delusions;
>
> ii) hallucinations;
>
> iii) serious disorders of the stream of thought;
>
> iv) serious disorders of thought form;
>
> v) serious disturbances of mood; *or*
>
> b) by sustained or repeated irrational behaviour that may be taken to indicate the presence of at least one of the symptoms referred to in paragraph (a). [emphasis added]

Section 6 also stipulates the necessity to have regard to internationally accepted clinical standards, for example, as determined by the World Health Organization or the American Psychiatric Association.

Like other states, the Northern Territory Act (s 6) provides that a person is *not* considered to have a mental illness merely because he or she:

- expresses or refuses or fails to express a particular political or religious opinion or belief, a particular philosophy or a particular sexual preference or sexual orientation;
- engages or refuses or fails to engage in a particular political, religious or cultural activity;

- engages, or has engaged, in sexual promiscuity, immoral or illegal conduct or anti-social behaviour;
- has a sexual disorder;
- is intellectually disabled;
- uses alcohol or other drugs;
- has a personality disorder or a habit or impulse disorder;
- has, or has not, a particular political, economic or social status;
- communicates, or refuses or fails to communicate, or behaves or refuses or fails to behave, in a manner consistent with his or her cultural beliefs, practices or mores;
- is, or is not, a member of a particular cultural, racial or religious group;
- is involved, or has been involved, in family or professional conflict;
- has been treated for mental illness or has been detained in a hospital that provides treatment of mental illness;
- has been admitted as an involuntary patient on the grounds of mental disturbance; or
- has acquired brain damage.

In addition to the definition of 'mental illness' in section 6, 'mentally disturbed' is defined in section 4 as follows:

> 'mentally disturbed' means behaviour of a person that is so irrational as to justify the person being temporarily detained under this Act.

Section 15 of the Act provides a more detailed understanding of what is meant by 'mental disturbance' as distinct from 'mental illness', and sets out the criteria for a person's involuntary admission on the grounds of mental disturbance as follows:

a) the person does not fulfil the criteria for involuntary admission on the grounds of mental illness;
b) the person's behaviour is, or within the immediately preceding 48 hours has been, so irrational as to lead to the conclusion that:
    i) the person is experiencing or exhibiting a severe impairment of or deviation from his or her customary or everyday ability to reason and function in a socially acceptable and culturally appropriate manner; and
    ii) the person is behaving in an abnormally aggressive manner or is engaging in seriously irresponsible conduct that justify a determination that the person requires psychiatric assessment, treatment or therapeutic care that is available at an approved treatment facility;
c) unless the person receives treatment or care at an approved treatment facility, he or she:
    i) is likely to cause imminent harm to himself or herself or to someone else; or
    ii) will represent a substantial danger to the general community; or
    iii) is likely to suffer serious mental or physical deterioration;

d) the person is not capable of giving informed consent to the treatment or care or has unreasonably refused to consent to the treatment or care; and
e) there is no less restrictive means of ensuring that the person receives the treatment or care.

The Act does not define a 'hospital', but instead, in section 4, defines an 'approved temporary treatment facility' and an 'approved treatment facility'. Both facilities are deemed to be, or be part of, places or premises declared as such for the purposes of section 20. That section states that the minister may declare a place or premises or part thereof to be an approved treatment facility or a temporary approved treatment facility for the provision of care and treatment under the Act. A similar provision applies to the declaration by the minister of a place to be an 'approved treatment agency' for the purposes of the Act.

One expression referred to frequently throughout the Act is the person's primary carer. Section 7A defines 'primary carer' as someone providing care and support as a relative or someone close to the person, or someone closely involved in the treatment or care of, or support to, the person. A relative of the person includes anyone related to the person through common ancestry, adoption, marriage, de facto relationship or any customary law or tradition (including Aboriginal law or tradition).

ADMISSION TO AND DETENTION IN AN APPROVED TREATMENT FACILITY

Voluntary admissions

Like most states, the Northern Territory makes provision for voluntary admissions; that is, persons who may voluntarily apply to be admitted to an 'approved treatment facility'.

Section 25 of the Act contains the provisions pertaining to voluntary admissions, which provide that a person who is aged 14 or over may apply to be admitted to an approved treatment facility as a voluntary patient. As well, a parent or guardian of a person who is under 18 may apply to have the person admitted to an approved treatment facility as a voluntary patient. Where either of those circumstances arises, a medical practitioner who is employed by an approved treatment agency or at an approved treatment facility must examine the person and may admit them if he or she is satisfied following examination that the person has given informed consent to his or her admission.

Within 72 hours after that admission, the person must be examined by an authorised psychiatric practitioner who may confirm the admission of the person as a voluntary patient if they are satisfied following such examination that the person has given informed consent to it. Equally the medical practitioner or authorised psychiatric practitioner may refuse to confirm the admission of a person as a voluntary patient and in those circumstances the person has the right to appeal to the Mental Health Review Tribunal (the tribunal) (s 25).

A person admitted as a voluntary patient can only be treated with his or her informed consent or that of his or her guardian — who must also be fully informed about the proposed treatment (s 54(1)).

If an authorised psychiatric practitioner has any doubts as to whether a person is capable of giving informed consent to treatment, an application must be made to the tribunal to determine the matter (s 54(4)). No treatment may be administered while awaiting the tribunal's decision unless it is necessary to prevent the person harming himself or herself or others, to prevent further deterioration in the person's condition and to relieve acute symptomatology (s 54(5)).

Section 7 defines 'informed consent'. It requires consent to be freely and voluntarily given in writing and the person to be capable of understanding the effect of giving consent. Section 7(3) lists the information that must be provided to a person to enable informed consent to be given. As well, steps must be taken to secure a 'competent interpreter' if required and the person must be given time to consider his or her decision once all the information is provided.

A voluntary patient may leave an approved treatment facility at any time and must be advised of that right when admitted as a voluntary patient (s 29).

A medical practitioner or senior registered nurse on duty may detain a voluntary patient for up to 6 hours if he or she believes the person's condition has deteriorated since admission and that the person may fulfill the criteria for admission as an involuntary patient. Where that occurs, an authorised psychiatric practitioner must be notified and reasonable force may be used to detain the person including restraint and seclusion (s 30).

Involuntary admission

Under the Act a person may be admitted on an involuntary basis on the grounds of mental illness or mental disturbance.

Involuntary admission on the grounds of mental illness

Section 14 of the Act sets out the criteria for the involuntary admission of a person on the grounds of mental illness as follows:

> a) the person has a mental illness;
> b) as a result of that mental illness:
> i) the person requires treatment that is available at an approved treatment facility;
> ii) without the treatment the person is likely to:
> A) cause serious harm to himself or herself or to someone else; *or*
> B) suffer serious mental or physical deterioration; *and*
> iii) the person is not capable of giving informed consent to the treatment or has unreasonably refused to consent to the treatment; *and*
> c) there is no less restrictive means of ensuring that the person receives the treatment. [emphasis added]

The criteria for admission on the grounds of mental disturbance that are set out in section 15 have been discussed above (see 'Objectives and definitions').

In the first instance, a person may request that he or she be assessed to determine whether they need treatment under the Act, or another person who is concerned about the person may request such an assessment (s 32). That request may be made

to a medical practitioner, a psychiatric practitioner or a designated mental health practitioner. Those persons may decline such a request if they believe the person does not need treatment (s 32(5)).

A designated mental health practitioner is a person appointed under section 23 of the Act and must be a psychologist, registered nurse, occupational therapist, aboriginal health worker, social worker or ambulance officer, all of whom must have two years' experience and undergone approved training. A psychiatric practitioner must be a specialist psychiatrist.

The assessment must be undertaken as soon as practicable (s 33). Following the assessment, a recommendation may be made by the assessing practitioner for a psychiatric examination to be undertaken if they are satisfied the person meets the criteria for involuntary admission on the grounds of mental illness or mental disturbance (s 34).

Once a recommendation for a psychiatric examination is made, the practitioner, ambulance officer or other person specified is authorised to control and bring the person to an approved treatment facility or hospital. If considered necessary, treatment may be administered to the person without the approval of the tribunal to prevent harm to the person or to others (s 34). The police may be asked to assist if necessary and may use reasonable force to do so. Additionally, a police officer may apprehend and bring a person to a psychiatric practitioner, medical practitioner or authorised mental health practitioner for assessment if the police officer believes the person may require treatment under the Act and is likely to cause harm to himself or herself or others. If necessary, the police officer may enter premises without a warrant to apprehend the person and use any reasonable force and assistance required (s 32A).

A practitioner or a police officer may ask the tribunal to issue an assessment warrant if they consider it necessary (s 37). If issued by the tribunal, the person may be apprehended, detained and taken to an approved treatment facility or other nominated place for assessment.

The recommendation for a psychiatric examination remains in force for 14 days. It may be revoked by the assessing practitioner following a further assessment. If revoked, the person must be released.

Once a person is detained as an involuntary patient following a recommendation for psychiatric examination, they may be detained at an approved treatment facility for up to 24 hours for examination by an authorised psychiatric practitioner. If an authorised psychiatric practitioner is satisfied, following the examination, that the person fulfils the criteria for involuntary admission, the person may be detained initially for 14 days (s 39). The person cannot be detained beyond that time unless an authorised psychiatric practitioner is satisfied that the person fulfils the criteria for involuntary admission on the grounds of mental illness or mental disturbance.

As an alternative to involuntary admission, the psychiatric practitioner may conclude that the person may be managed as an involuntary patient in the community. If so, he or she must make an interim community management order in relation to the person (s 38). However, if the person does not fulfil the criteria for admission as an involuntary patient on the grounds of mental illness or mental disturbance or for involuntary community treatment, the person must be released.

Once the person is admitted as an involuntary patient he or she must be examined by an authorised psychiatric practitioner not less than once every 72 hours.

No later than 1 day following detention on the grounds of mental illness or mental disturbance, the practitioner must notify the person of the admission, as well as a legal practitioner who is prepared to act on behalf of the person. Where considered to be in the patient's best interests the person's primary carer, or a person closely involved in the treatment or care of the person, must also be notified of the grounds on which the person was admitted and the section under which the person was admitted (s 41).

Involuntary admission on the grounds of mental disturbance

Where a patient is detained as an involuntary patient on the grounds of mental disturbance, he or she may be initially detained for 72 hours. The person may be detained for a further 7 days if, after examining the person, two authorised psychiatric practitioners believe the person needs care and treatment and that the person is not capable of consenting or unreasonably refuses to give such consent and there is no less restrictive way to provide the necessary care and treatment (s 42). During that period, the person must be examined by an authorised psychiatric practitioner every 24 or 72 hours depending on the basis for detention (s 44). Before the 7-day period expires, the person may be admitted as a voluntary patient, admitted as an involuntary patient on the grounds of mental illness, placed on an interim community management order, or released.

No later than 1 day after being detained, a practitioner must notify the person, the person's adult guardian, a legal practitioner acting for the person, the person's primary carer and the tribunal of the admission. A decision may be taken not to notify the person's primary carer if it is considered not to be in the person's best interests (s 43).

If the person is released and an authorised psychiatric practitioner considers that he or she may cause imminent harm to others on his or her release, that practitioner must notify the Commissioner of Police or a designated member of the police force. Also, the practitioner must notify, where practicable, those persons who may be in danger, not less than 12 hours before the person is released (s 44(4)).

Treatment and review after involuntary admission

The Mental Health Review Tribunal is required to review a decision of an authorised psychiatric practitioner to detain a person on the grounds of mental illness or mental disturbance, or making the person subject to an involuntary interim community management order, within 7 days of that person's being involuntarily detained or made subject to an involuntary interim community management order (s 123).

In undertaking that review, the tribunal may uphold the decision of the practitioner or substitute its own decision including revoking the admission of the person as an involuntary patient or as a subject to an involuntary interim community management order (s 123(5) and (7)).

In relation to a person detained on the grounds of mental illness, if the tribunal decides to continue the person's detention, it must be for no longer than 3 months

and the tribunal must fix a date on which that order is to be further reviewed (s 123(5)(a)). If the tribunal is satisfied the person fulfills the criteria for involuntary admission on the grounds of mental disturbance, it may order the person to be detained for no longer than 14 days and, in doing so, must fix a date for that order to be reviewed (s 123(5)(b)). If the tribunal is satisfied the person is able to be treated as an involuntary patient in the community, it may make a community management order for no longer than 6 months and, in doing so, must fix a date for that order to be reviewed (s 123(5)(c)).

Any treatment given to a person after an involuntary admission must be authorised by the tribunal unless administered to prevent harm to the person or to others. Such treatment must be authorised by an authorised psychiatric practitioner (s 55). Every effort must be made to involve the person in considering the appropriate treatment and any alternatives available.

In considering treatment options, the tribunal or an authorised psychiatric practitioner must consider the treatment that is in the person's best interests, that the benefits outweigh the risks, that alternative treatment is not readily available and the treatment is the least restrictive option (s 56). Records must be kept of whatever treatment options are decided upon (s 57).

FORMS AND TYPES OF TREATMENT UNDER THE ACT

Community management orders

Like most states, the Northern Territory makes provision for persons to be treated in the community rather than having to be admitted to an approved treatment facility. In the first instance, this is by way of an *interim* community management order which, if confirmed by the tribunal, is renewed as a community management order.

An authorised psychiatric practitioner may make an interim community management order in the first instance in respect of a person where that practitioner is satisfied that the person fulfils the criteria for involuntary treatment in the community (s 45(1)).

An interim community management order should not be made unless it is approved by the person in charge of an approved treatment facility who agrees that it is appropriate and able to be implemented by an approved treatment agency or, where the person is a prisoner, that it is able to be implemented in the prison where the person is in custody (s 45(2)).

An interim community management order remains in force for 14 days and the following treatment may be administered under such an order (s 45(4)):

- treatment that will prevent the person causing imminent harm to himself or herself or someone else;
- treatment that will prevent behaviour of the person that is likely to cause imminent harm to himself or herself or someone else;
- treatment that will prevent any further physical or mental deterioration of the person;
- treatment that will relieve acute symptomatology.

An interim community management order must contain specific provisions including the approved treatment agency that is to supervise it, where the treatment

is to occur as well as details of the treatment to be given (s 46). As well, once an interim community management order has been made the authorised psychiatric practitioner must, no later than 1 day after making the order, notify the Mental Health Review Tribunal of its being made (s 47). The practitioner must also notify the person himself or herself, their legal practitioner, the person's primary carer and the principal community visitor that the order has been made.

Once the Mental Health Review Tribunal has been notified that an interim community management order has been made, it must review that order as soon as practicable within 14 days. Having done that, the tribunal may confirm a community management order in relation to a person for no longer than 6 months and, where it does so, must fix a date for the order to be reviewed again (s 123).

A community management order must be in writing and specify the following (s 49):

- the name and residential address of the person to whom it relates;
- the name of the approved treatment agency that is to supervise and review the community management order;
- the name of the approved treatment agency that is to implement the community management order;
- the organisations or persons (other than the approved treatment agency) treating or caring for the person under the community management order;
- the time and days of the week when a person is to attend the approved treatment agency or when a person treating or caring for the person will attend the person's residence;
- the medication or treatment the person is to receive under the community management order;
- the rehabilitation, support and other services the person is to receive under the community management order; *and*
- any other information the tribunal thinks fit.

THE REGULATION AND PROHIBITION OF CERTAIN FORMS OF TREATMENT UNDER THE ACT

Psychosurgery, deep sleep therapy, insulin therapy and sterilisations

Psychosurgery as defined in section 58, deep sleep therapy, insulin coma or sub-coma therapy (s 59), and sterilisation as a treatment for mental illness or mental disturbance (s 60) are all prohibited under the Act. Any person who performs any of those treatments on a person is liable to a penalty of $10 000.

Mechanical means of bodily restraint

Mechanical restraint is defined in section 61 of the Act as the application of a device (including a belt, harness, manacle, sheet and strap) on a person's body to restrict the person's movement, but does not include the use of furniture (including a bed with cot sides and a chair with a table fitted on its arms) that restricts the person's capacity to get off the furniture.

Mechanical restraint of a person in an approved treatment facility may only be applied where no other less restrictive method of control is applicable and it is necessary for the purposes of medical treatment to prevent the person from causing injury to himself or herself or others and to prevent the person from persistently destroying property or absconding from the facility.

Mechanical restraint cannot be applied unless it is approved by an authorised psychiatric practitioner or, in the case of an emergency, the senior registered nurse on duty. Where it is approved by the senior registered nurse on duty, he or she must notify the person in charge of the approved treatment facility and an approved psychiatric practitioner as soon as practicable. The form of the mechanical restraint to be used and the duration of its application must be determined by the authorised psychiatric practitioner or senior registered nurse who approves it and such restraint may be applied without the person's consent.

If mechanical restraint is to be applied, the person to whom it is applied (s 61(8)):

- must be kept under continuous observation by a registered nurse or medical practitioner;
- must be reviewed, as clinically appropriate to his or her condition, by a registered nurse at intervals of no longer than 15 minutes;
- subject to any other direction, must be examined by a medical practitioner at intervals of no longer than 4 hours;
- must be reviewed by an authorised psychiatric practitioner if the mechanical restraint remains applied for 6 hours;
- must be supplied with bedding and clothing that is appropriate in the circumstances;
- must be provided with food and drink at appropriate times;
- must have access to adequate toilet facilities; *and*
- must be provided with any other psychological and physical care appropriate to the person's needs.

Any mechanical restraint applied to a voluntary patient must not be for a period longer than 6 hours (s 61(10)).

Records of restraint applied must be kept and a copy placed in the person's medical record (s 61(13)). The record must note (s 61(12)):

- the form of restraint applied;
- the reasons why restraint was applied;
- the name of the person who approved the restraint;
- the name of the person who applied the restraint;
- the period of time the restraint was applied.

The person in charge of an approved treatment facility must ensure that the adult guardian of a patient where restraint is applied is notified as soon as possible:

- that mechanical restraint was applied to the person;
- the reasons why the mechanical restraint was applied;

- the form of restraint applied; and
- the period of time the restraint was applied.

Seclusion

For the purposes of section 62 of the Act 'seclusion' means the confinement of the person, at any hour of the day or night, in a room from which free exit is prevented.

The provisions in relation to placing a person in seclusion, insofar as the question of authority and records that must be kept of that process, are in relatively similar terms to that of mechanical restraint. Where a person is kept in seclusion he or she (s 62(8)):

- must be visited by a registered nurse at intervals of no longer than 15 minutes;
- must be examined by a medical practitioner at intervals of no longer than 4 hours;
- must be reviewed by an authorised psychiatric practitioner, if the person is kept in seclusion for more than 6 hours;
- must be supplied with bedding and clothing that is appropriate in the circumstances;
- must be provided with food and drink at appropriate times;
- must have access to adequate toilet facilities; *and*
- must be provided with any other psychological and physical care appropriate to the person's needs.

Similar provisions apply to the keeping of records in relation to seclusion as are required in relation to restraint.

Electroconvulsive therapy (ECT)

Electroconvulsive therapy is permitted in accordance with the provisions set out in section 66 of the Act. ECT must not be performed unless the person's informed consent is obtained or the person's adult guardian consents (s 66(1)). Where a person is unable to give informed consent, the tribunal may authorise ECT where two psychiatric practitioners report that the person's condition is such that ECT is reasonable and proper treatment and the person's primary carer cannot be located (s 66(2)). At least two qualified medical practitioners must be present when ECT is performed (s 66(6)).

ECT may be performed on a person who is an involuntary patient without the tribunal's consent where two authorised psychiatric practitioners are satisfied that it is immediately necessary to save the person's life, to prevent the person suffering serious mental or physical deterioration, or to relieve severe distress (s 66(3)). Where ECT is performed without the authority of the Mental Health Review Tribunal, the tribunal is required to be advised as soon as practicable after it is performed.

Non-psychiatric treatment

Where necessary, medical or surgical treatment that is unrelated to a mental illness or mental disturbance may be administered to a person where the consent

of the person or the person's guardian is obtained or it is approved by the tribunal (s 63). For example, a person may require surgery to repair a hernia or medication for hypertension. Such treatment is referred to as 'non-psychiatric treatment'.

The Act precludes clinical or experimental treatment on a person who is an involuntary patient or subject to a community management order unless approved by an ethics committee and the informed consent of the person is obtained or approval given by the tribunal (s 65).

PATIENT RIGHTS, COMMUNITY VISITORS AND APPEAL MECHANISMS UNDER THE ACT

Patient rights

Section 87 provides that, no later than 1 day after a person is admitted to an approved treatment facility or a community management order is made in respect of that person, the person in charge of the approved treatment facility or approved treatment agency must ensure that the person is given information setting out the person's rights and entitlements under the Act, how those rights and entitlements may be accessed and exercised, the advocacy and legal services that are available to the person, and any other information relating to the person's admission and treatment as may be considered relevant. As much as possible of that information must be given both orally and in writing and in a language and in a form which the person can readily understand and which is culturally appropriate.

The person in charge of an approved treatment facility must also ensure that the person and, if considered to be in the person's best interests, the person's primary carer, is provided with information as far as is practicable of the details of the type, dosage, expected benefits and side effects of the medication or treatment being administered to the person at an approved treatment facility. Likewise, in relation to a community management order being supervised by an approved treatment agency (s 88).

Community visitors

The Act provides for the appointment of persons known as community visitors. Their task, like that of official visitors in most other states, is to inquire into and make recommendations relating to (s 104):

- the adequacy of services for accessing and treating persons in approved treatment facilities or by approved treatment agencies;
- the standard and appropriateness of facilities for the accommodation, physical wellbeing and welfare of persons receiving treatment or care at approved treatment facilities or by approved treatment agencies;
- the adequacy of information relating to the rights of persons receiving treatment at approved treatment facilities or by approved treatment agencies and the complaint procedures under the Act;
- the accessibility and effectiveness of complaint procedures under the Act;
- the failure of persons employed in approved treatment facilities or by approved treatment agencies to comply with the provisions of the Act;

- any other matter that a community visitor considers appropriate having regard to the principles and objectives of the Act; and
- any other matter as directed to the principal community visitor by the Minister for Health.

Community visitors are empowered to visit approved treatment facilities or approved treatment agencies and provide reports arising from their visits, including any findings or recommendations, to the principal community visitor. Any person who is receiving treatment or care at an approved treatment facility or by an approved treatment agency must be able to access the community visitors when they visit that facility on a regular basis (s 108).

MENTAL HEALTH REVIEW TRIBUNAL

The Mental Health Review Tribunal is established under section 118 of the Act and its major roles are to:

- review long-term voluntary admissions (s 122);
- review involuntary admissions and community management orders (s 123);
- review reports as provided to it (s 125);
- hear appeals against decisions of a medical practitioner or an authorised psychiatric practitioner under certain sections of the Act (s 127).

An application may be made to the tribunal by the person who is the subject of the tribunal's decision. As well, an application may be made on the person's behalf by the person's adult guardian, representative, legal practitioner, or a person with a genuine interest and concern for the person (s 127(3)).

The tribunal has the power to make orders to vary, affirm or set aside orders already made.

APPEALS TO THE SUPREME COURT OF THE NORTHERN TERRITORY

Section 142 of the Act provides that a person aggrieved by a decision or refusal of the tribunal within a reasonable time to make a decision may appeal to the Supreme Court against that decision or refusal. Also, a person who has a sufficient interest in the matter which is the subject of a decision or refusal of the tribunal may, with the leave of the Supreme Court, appeal to the court against that decision or refusal. Any such appeal is by way of a rehearing and, in determining the appeal, the Supreme Court may (s 143):

- affirm, vary or set aside the decision or order of the tribunal;
- make any decision or order that the tribunal may have made;
- remit the matter to the tribunal for further consideration;
- make any other order that it thinks fit.

Queensland: *Mental Health Act 2000*

The Queensland mental health legislation makes provision for the involuntary assessment, treatment and protection of persons (whether adults or minors) who

have a mental illness while safeguarding their rights (s 4). Section 8 sets out the principles to be observed in the administration of the Act, while section 9 sets out those that must be observed when exercising the powers and functions provided in the Act for the care and treatment of persons with a mental illness or intellectual disability. Emphasis is placed taking on the least restrictive approach to treatment and keeping any adverse impact on a person's liberty and rights to a minimum having regard to the circumstances.

While the Act focuses on involuntary patients, provision is made in section 6 for the voluntary assessment or treatment of a person; it states that the Act 'does not prevent a person who has a mental illness being admitted to, or receiving assessment or treatment at an authorised mental health service other than as an involuntary patient'.

DEFINITIONS

The schedule at the end of the Act contains an extensive dictionary that sets out the meaning of key words for the purposes of the Act. Reference should be made to it prior to any detailed consideration of the Act. The definition of 'mental illness', however, is found in section 12 as follows:

1) **Mental illness** is a condition characterised by a clinically significant disturbance of thought, mood, perception or memory.
2) However, a person must not be considered to have a mental illness merely because of any 1 or more of the following—
   a) the person holds or refuses to hold a particular religious, cultural, philosophical or political belief or opinion;
   b) the person is a member of a particular racial group;
   c) the person has a particular economic or social status;
   d) the person has a particular sexual preference or sexual orientation;
   e) the person engages in sexual promiscuity;
   f) the person engages in immoral or indecent conduct;
   g) the person takes drugs or alcohol;
   h) the person has an intellectual disability;
   i) the person engages in antisocial behaviour or illegal behaviour;
   j) the person is or has been involved in family conflict;
   k) the person has previously been treated for mental illness or been subject to involuntary assessment or treatment.
3) Subsection (2) does not prevent a person mentioned in the subsection having a mental illness.

Examples of where subsection (3) would be relevant include where:

- a person may have a mental illness caused by taking drugs or alcohol;
- a person may have a mental illness as well as an intellectual disability;
- on an assessment, a decision that a person has a mental illness has been made in accordance with internationally accepted medical standards.

ADMISSION TO AND DETENTION IN AN AUTHORISED MENTAL HEALTH SERVICE

The dictionary contained in the schedule of the Act defines an 'authorised mental health service' as follows:

> a) generally—means a mental health service declared under section 495 to be an authorised mental health service; or
> b) for chapter 2—see section 15.

Chapter 2 of the Act (ss 15–48 inclusive) deals with the involuntary assessment of a person. Within that chapter, section 15 defines, for the purposes of Chapter 2, an 'authorised mental health service' as follows:

> a) an authorised mental health service, other than a high security unit; or
> b) a public hospital if there is no authorised mental health service readily accessible for a person's examination or assessment.

An example of the application of paragraph (b) above is where there is no authorised mental health service in a remote or rural area of the state.

For the purposes of admission, the Act designates the admission of persons to an authorised mental health service or hospital as voluntary or involuntary.

Voluntary admission

Section 6 of the Act provides for the voluntary admission and discharge of persons at their own request.

Involuntary admission

Under sections 17 and 19, the process leading to an involuntary admission to an authorised mental health service is triggered when the assessment of a person is requested or recommended. In the first instance, section 17 provides that a 'request' for assessment of a person must be made by someone who:

> a) is an adult; *and*
> b) reasonably believes the person has a mental illness of a nature, or to an extent, that involuntary assessment is necessary; *and*
> c) has observed the person within 3 days before making the request. [emphasis added]

Alternatively, section 19 provides that a 'recommendation' for assessment can only be made in the following circumstances:

> 1) A recommendation for assessment for a person may only be made by a doctor or authorised mental health practitioner who has examined the person within the preceding 3 days.
> 2) However, a doctor or authorised mental health practitioner must not make a recommendation for assessment for a relative of the doctor or practitioner.
> 3) An examination mentioned in subsection (1) may be carried out using audiovisual link facilities.

An 'authorised mental health practitioner' is defined in section 499 of the Act as a health service employee of an authorised mental health service or an officer of the

department. A healthcare practitioner may only be appointed as an authorised mental health practitioner if the Director of Mental Health considers he or she has the necessary expertise and experience.

Section 23 of the Act provides that a request and recommendation for assessment must be made by different persons who must not be related.

In making a recommendation for assessment, section 20 provides it must:

a) be in the approved form; *and*
b) state the facts on which it is based; *and*
c) distinguish between the facts known because of personal observation and facts communicated by others. [emphasis added]

A doctor or authorised mental health practitioner must not make a recommendation for assessment for a person unless the doctor or practitioner is satisfied the assessment criteria apply to the person. Section 13 outlines what constitutes the assessment criteria; it states that 'assessment criteria are all of the following, based on information available':

a) the person appears to have a mental illness;
b) the person requires immediate assessment;
c) the assessment can properly be made at an authorised mental health service;
d) there is a risk that the person may—
   i) cause harm to himself or herself or someone else; or
   ii) suffer serious mental or physical deterioration;
e) there is no less restrictive way of ensuring the person is assessed.

As well, where involuntary detention occurs, the criteria include the person himself or herself lacking the capacity to consent to being assessed or having unreasonably refused to be assessed.

Where assessment documents are in force, a healthcare practitioner or ambulance officer may take a person to an authorised mental health service for assessment (s 25(1)). While being taken to an authorised mental health service, medication may be administered to the person without his or her consent or where consent is refused (s 26(1)). Such medication may only be administered if a medical practitioner is satisfied it is necessary to ensure the person's safety or that of others. A medical practitioner or registered nurse must administer the medication using the minimum force necessary and reasonable (s 26(2) and (3)).

The police may be called upon to assist in taking a patient to an authorised mental health service and to ensure that reasonable help is given to do so (s 25(3)).

A recommendation for assessment remains in force for a period of 7 days (s 21).

JUSTICES EXAMINATION ORDER

A recommendation for assessment may be made following an application by 'a person' to a magistrate or justice of the peace for what is referred to as a 'justices examination order'.

Section 28 sets out the circumstances in which such an order may be made as follows:

1) A magistrate or justice of the peace may make a justices examination order relating to a person only if the magistrate or justice reasonably believes—
   a) the person has a mental illness; *and*
   b) the person should be examined by a doctor or authorised mental health practitioner to decide whether a recommendation for assessment for the person be made; *and*
   c) the examination can not be properly carried out unless the order is made. [emphasis added]

Once such an order is made it must be sent to an authorised mental health service. Certain consequences then follow, as section 30 provides:

1) The justices examination order authorises a doctor or authorised mental health practitioner to examine the person to decide whether a recommendation for assessment for the person should be made.
2) For subsection (1), the doctor or practitioner may enter a place stated in the order or another place the doctor or practitioner reasonably believes the person may be found.
3) The doctor or practitioner may exercise a power under this section with the help that is reasonable in the circumstances.
4) For subsections (1) and (2)—
   a) the doctor or practitioner is a public official for the *Police Powers and Responsibilities Act 2000*; and
   b) a police officer may detain the person at the place for the examination to be carried out by a doctor or authorised mental health practitioner.
5) If asked by the doctor or practitioner, a police officer must, as soon as reasonably practicable, ensure reasonable help is given.
6) For giving the help, a police officer is taken to have responded to a request by a public official under the *Police Powers and Responsibilities Act 2000*, section 16(3).
7) In exercising a power under this section, the doctor or practitioner must, to the extent that it is reasonable and practicable in the circumstances—
   a) explain to the person, in general terms, the nature and effect of the order; and
   b) produce the order to the person for inspection.
8) Production by the doctor or practitioner of a facsimile copy of the order is sufficient compliance with subsection (7)(b).
9) Failure to comply with subsection (7) does not affect the validity of the exercise of the power.
10) A power under this section may be exercised at any reasonable time of the day or night.

EMERGENCY INVOLUNTARY ASSESSMENT

In addition to a justices examination order, the Act also provides that, in emergency circumstances, recommendation for assessment for a person may be made by a police officer, an ambulance officer and a psychiatrist (ss 33–40).

A police officer or an ambulance officer may take a person to an authorised mental health service for examination to decide if a request or recommendation for assessment should be made if the officer reasonably believes:

a) a person has a mental illness; and
b) because of that there is an imminent risk of significant physical harm to the person or others; and
c) any delay would be dangerous and increase the risk of harm.

Once the person is at the authorised mental health service, the police officer or ambulance officer must make an emergency examination order (s 35). That order allows a person to be detained for a maximum of 6 hours for examination by a doctor or a mental health practitioner (s 36).

The emergency examination by a psychiatrist may be undertaken if the psychiatrist considers that the person has a mental illness and 'there is an imminent risk of significant physical harm being sustained by the person or someone else' (s 37(b)) and where referral to a magistrate or justice would cause delay and significant risk of harm to others as well as the person (s 37(c)). Following the production of the emergency examination order, the person may be transferred to an authorised mental health service and detained for a maximum of 6 hours for the examination to be conducted (s 40).

INVOLUNTARY TREATMENT ORDER

Section 44(1) allows a person to be detained in an authorised mental health service for assessment. The assessment period is initially no longer than 24 hours but may be extended by a medical practitioner for no longer than a further 24 hours but overall must not extend more than 72 hours.

The initial assessment made by the authorised medical practitioner is to decide whether the treatment criteria apply to the person. If so, an involuntary treatment order will be made for the patient.

Section 14 defines the expression 'treatment criteria' for a person as all of the following:

a) the person has a mental illness;
b) the person's illness requires immediate treatment;
c) the proposed treatment is available at an authorised mental health service;
d) because of the person's illness—
    i) there is an imminent risk that the person may cause harm to himself or herself or someone else; or
    ii) the person is likely to suffer serious mental or physical deterioration;
e) there is no less restrictive way of ensuring the person receives appropriate treatment for the illness;
f) the person—
    i) lacks the capacity to consent to be treated for illness; or
    ii) has unreasonably refused proposed treatment for the illness.

Section 108 contains the provisions applying to the making of an involuntary treatment order. The order has to be in the approved form and must contain the details as required in section 108(3)(b):

i) the time when it is made;
ii) the basis on which the doctor is satisfied the treatment criteria apply to the patient, including the facts indicating mental illness observed by the doctor;
iii) the authorised mental health service responsible for ensuring the person receives treatment.

When an involuntary treatment order is made it must be categorised as either an inpatient or community involuntary treatment order (s 109). If it is categorised as inpatient, the person may be detained in an authorised mental health service as an involuntary patient and the authorised doctor must tell the patient of the order made, the category of the order and talk with the patient about the proposed treatment plan (s 111). Once a person becomes an involuntary patient, the administrator of an authorised mental health service must inform the patient, the tribunal and the patient's allied person in writing within 7 days (s 113).

If an involuntary treatment order is categorised as a community order, the person may be treated in the community.

TREATMENT PLANS

Once an involuntary treatment order is made, a treatment plan must be prepared (s 110). As provided in section 124, a patient's treatment plan must state:

a) in general terms, an outline of the proposed treatment or care to be provided in relation to the patient; and
b) in specific terms, the method by which, the frequency with which, the place where, the duration of and the persons by whom, the treatment or care is to be provided; and
c) the intervals for the patient's regular assessment.

…

2) Also, for a patient under the community category of an involuntary treatment order, the treatment plan for the patient must—

a) if the patient is to be treated at a health service other than an authorised mental health service—state the health service; and
b) if the patient is to be treated by a health practitioner who is not an employee of a public sector mental health service—state the name of the practitioner.

3) However, the treatment plan may only state a health practitioner under subsection (2)(b) with the practitioner's agreement.

There is provision for an involuntary patient's treatment plan to permit limited community treatment for the patient, provided it does not present an unacceptable risk to the public. Limited community treatment is treatment or rehabilitation in

the community other than under the community category of an involuntary treatment order.

THE ROLE OF THE MENTAL HEALTH REVIEW TRIBUNAL AND MENTAL HEALTH COURT

The Act makes provision for the following:

- the Mental Health Review Tribunal;
- the Mental Health Court.

The setting up of these two bodies and their respective jurisdictional roles are essentially complementary, with the role of the Mental Health Court, amongst others, to hear and determine appeals from the tribunal.

Mental Health Review Tribunal

Section 437 of the Act sets out the jurisdiction of the tribunal as follows:

a) reviewing the application of treatment criteria for patients;
b) reviewing the detention of young patients in high security units;
c) reviewing the mental condition of forensic patients and forensic disability clients;
d) reviewing the fitness for trial of—
    i) persons found by the Mental Health Court to be unfit for trial and the unfitness for trial is not of a permanent nature; and
    ii) persons for whom a jury has made a section 613 or 645 finding;
e) deciding applications for forensic information orders;
f) deciding treatment applications;
g) deciding applications for approval for particular patients to move out of Queensland;
h) deciding appeals against decisions of administrators of authorised mental health services to refuse to allow persons to visit involuntary patients in health services; …

The tribunal is required to conduct reviews of the treatment criteria for patients under involuntary treatment orders 6 weeks after the initial order is made and thereafter every 6 months (s 187).

A review may also take place if an application has been made by, or on behalf of, a patient or the Director of Mental Health. In conducting a review the tribunal must consider the provisions detailed in sections 187 and 188 of the Act.

If an involuntary treatment order has been in force for more than 6 months, the tribunal is to consider whether an examination and report should be obtained from a psychiatrist, other than the psychiatrist responsible for the patient's treatment (s 190). In hearing the matter, the tribunal may either confirm or revoke the involuntary treatment order. If the tribunal confirms the order, it may direct that category be changed from a hospital order to a community order or detention in another mental health service. In making such a direction, the tribunal is to have regard to

the patient's mental state and psychiatric history, social circumstances and response to treatment and willingness to continue treatment (s 191).

A party may appeal against a decision of the tribunal to the Mental Health Court.

Mental Health Court

The court comprises a Supreme Court Judge sitting alone, assisted by two psychiatrists, or one in certain circumstances (s 382).

The powers of the Mental Health Court, as provided in section 383, are:

1) …
   a) deciding appeals against decisions of the tribunal;
   b) deciding references of the mental conditions of persons;
   c) investigating the detention of patients in authorised mental health services …
2) In exercising its jurisdiction, the court—
   a) must inquire into the matter before it; and
   b) may inform itself of any matter relating to the inquiry in any way it considers appropriate.

FORMS AND TYPES OF TREATMENT UNDER THE ACT

As referred to above, the Act provides for an involuntary treatment order to be made (s 108), which is supported by a treatment plan (s 110). An involuntary treatment order may be categorised as an inpatient or community involuntary treatment order.

An involuntary treatment order remains in force until it is revoked by the authorised doctor or on review or appeal. If no treatment has been given under the treatment plan for a period of six months the involuntary treatment order ends (s 118).

Where a person is the subject of an involuntary treatment order in the community and fails or refuses to comply with the treatment plan prescribed, steps may be taken to have the person apprehended and admitted as an involuntary patient to an authorised mental health service for treatment (s 117).

Electroconvulsive therapy (ECT)

The Act makes specific reference to electroconvulsive therapy (ECT) and psychosurgery.

The administration of ECT is provided for in sections 138–140. The circumstances in which ECT may be administered, on the basis of informed consent or otherwise, is set out in section 139 as follows:

1) A doctor may perform electroconvulsive therapy on a person at an authorised mental health service if—
   a) the person has given informed consent to the treatment; or
   b) the tribunal has approved the use of the treatment on the person.
2) However, a doctor must not, under subsection (1)(b), perform electroconvulsive therapy on a person who is not an involuntary patient if the doctor knows the person objects to the therapy.
3) In this section—
   object, for a person, means—

a) the person indicates the person does not wish to have electroconvulsive therapy; or
b) the person previously indicated, in similar circumstances, the person did not then wish to have electroconvulsive therapy and since then the person has not indicated otherwise.

Section (3)(b) example

An indication may be given in an enduring power of attorney or advance health directive or in another way, including, for example, orally or by conduct.

The Act requires that informed consent to ECT must be given in writing. Prior to obtaining a person's written consent he or she must be given the fullest explanation as to the purpose, method, likely duration and expected benefit of ECT as well as the possible pain, discomfort, risks and side effects of the treatment and alternative treatments available (s 137).

ECT may be administered in an emergency if it is considered necessary to save the patient's life or to prevent the patient suffering irreparable harm (s 140).

Psychosurgery

Section 161 of the Act makes provision for this treatment in the following terms:

1) A person must not perform psychosurgery on another person other than under this section.
   Maximum penalty—200 penalty units or 2 years imprisonment.
2) A doctor may perform psychosurgery on a person if:
   a) the person on whom the treatment is performed has given informed consent to the treatment; *and*
   b) the tribunal has given approval to the treatment. [emphasis added]

The information to be given to a person prior to obtaining the person's written consent to perform psychosurgery is the same as that applying to ECT treatment detailed above.

TREATMENT PROHIBITED BY THE ACT

Section 162 specifically prohibits the administration of insulin-induced coma therapy or deep sleep therapy treatment.

RESTRAINT AND SECLUSION

The power to restrain patients in mental health facilities or to place a patient in seclusion can be a very contentious issue in the care of involuntary mentally ill patients. For good and sound reasons, the Act makes very detailed provisions concerning these matters. Because restraint and detention orders invariably involve nursing staff, the legislative provisions in relation to these two matters should be known by all nursing staff caring for involuntary patients in authorised mental health services in Queensland.

Restraint

Sections 162A–162I inclusive contain the provisions in relation to restraint. A definition of 'mechanical restraint' is to be found in section 162A, and section 162D allows a doctor to authorise mechanical restraint if the doctor is satisfied:

> … it is the most clinically appropriate way of preventing injury to the patient or someone else.

In authorising such restraint the doctor is required to record the following details in the patient's clinical file (s 162E):

a) the type of restraint authorised;
b) the reasons for the restraint;
c) any restrictions on the circumstances in which restraint may be applied;
d) the maximum period or periods for which the restraint may be applied;
e) the intervals at which the patient must be observed while the restraint is applied;
f) any special measures necessary to ensure the patient's proper treatment or care while the restraint is applied;
g) the time (not longer than 3 hours after the authorisation is given) when the authorisation ends.

Once authorised, the obligations of the senior registered nurse are also provided for in the following terms (s 162G):

> The senior registered nurse on duty must—
> a) ensure the restraint is applied as authorised by the doctor; *and*
> b) ensure the patient's reasonable needs are met, including for example, being given—
> i) sufficient bedding and clothing; *and*
> ii) sufficient food and drink; *and*
> iii) access to toilet facilities; *and*
> c) record the following details in the patient's clinical file—
> i) the type of restraint applied;
> ii) if the doctor has stated any restrictions on the application of the restraint—the circumstances in which the restraint was applied;
> iii) the time the restraint was applied;
> iv) the person who applied the restraint;
> v) the time the restraint was removed. [emphasis added]

Section 162H permits the senior registered nurse, if satisfied the patient can be safely treated without the restraint, to immediately direct the removal of the restraint.

Seclusion

Sections 162J–162W inclusive contain the provisions in relation to seclusion. Both a doctor and, in urgent circumstances, the senior registered nurse on duty may authorise seclusion (s 162L).

The circumstances warranting seclusion are contained in section 162M, that is:

a) it is necessary to protect the patient or other persons from imminent physical harm; and
b) there is no less restrictive way of ensuring the safety of the patient or others.

Provision is made that seclusion orders must be documented (s 162O), continuous observations must be maintained (ss 162P and 162S), there are circumstances in which the senior registered nurse may end and authorise seclusion (ss 162Q and 162R), there are requirements as to ensuring the patient's needs are met (s 162T) and there are times the use of reasonable force may be necessary (s 162U).

PATIENT RIGHTS, REVIEW OF CARE AND APPEAL MECHANISMS UNDER THE ACT

Allied person

Unlike other states who use the term 'official visitor' or 'community visitor', Queensland has provided for an involuntary patient to choose a person to be an 'allied person'. Sections 340 and 341 set out the role of that person and how the person may be chosen, as follows:

> *Section 340 Function of allied person*
>
> The function of an involuntary patient's allied person is to help the patient to represent the patient's views, wishes and interests relating to the patient's assessment, detention, treatment and care under this Act.
>
> *Section 341 Patient may choose allied person*
>
> 1) An involuntary patient may choose any 1 of the following persons, other than a health service employee at the patient's treating health service, who is capable, readily available and willing to be the patient's allied person for this Act—
>
> a) if the patient is a minor—a parent of the minor or the minor's guardian;
> b) if the patient has a personal guardian—the guardian;
> c) if the patient has a personal attorney—the attorney;
> d) an adult relative or adult close friend of the patient;
> e) an adult carer of the patient;
> f) another adult.

In circumstances where the patient does not have the capacity to choose an allied person, section 342 provides the alternatives that must be followed.

Statement of rights

Both the patient and the patient's allied person must be given a statement of rights in a language that they understand (s 345), and it must contain (s 344):

a) the rights of patients and allied persons for patients under this Act;
b) the rights of patients to make complaints about the service provided at an authorised mental health service and how the complaints are made.

The statement may also contain anything else the director considers appropriate, including, for example, information for relevant standards for providing mental health services.

Appeal rights

The right of a patient or a person acting on his or her behalf to appeal to the tribunal for a review of an involuntary treatment order has already been detailed above as well as the right of a party to appeal a decision of the tribunal to the Mental Health Court.

South Australia: *Mental Health Act 2009*

The *Mental Health Act 2009* commenced in July 2010. The objectives of the Act (s 6) are to ensure that people with a serious mental illness:

- receive a comprehensive range of services of the highest standard for their treatment, care and rehabilitation with the goal of bringing about their recovery as far as is possible; and
- retain their freedom, rights, dignity and self-respect as far as is consistent with their protection, the protection of the public and the proper delivery of the services; and
- in order to do that, allow for such persons to receive community treatment or detention and treatment where required.

Additionally, section 7 of the Act establishes the guiding principles to be observed by the Minister, the Board, Chief Psychiatrist, healthcare professionals and other persons and bodies in the administration of the Act and the discharge of their respective functions.

Reference to 'the Board' throughout the Act means the Guardianship Board, established under the *Guardianship and Administration Act 1993* (SA). The Guardianship Board plays a significant role in the review, and the making, of detention and treatment orders under the *Mental Health Act*.

DEFINITIONS

The definitions of relevant words used in the Act are generally found in section 3. For example, the definition of 'mental illness' for the purposes of the Act is expressed as 'any illness or disorder of the mind'. The definition is extremely general in nature. Indeed, the absence of clarity in the definition leaves the judgment as to what is or is not mental illness and who is or is not suffering from mental illness largely up to the determination of the individual psychiatrist or medical practitioner or to the courts if they are ever called upon to do so.

The definition of mental illness in section 3 is subject to Schedule 1 of the Act which lists certain conduct, some 13 types in all, that may *not*, by itself, indicate mental illness. It includes, for example, that a person expresses or refuses or fails to express a particular opinion or belief as to politics or religion, or a particular philosophy, or sexual preference or orientation. Significantly, subclause (j) of Schedule 1 identifies that where a person 'has developmental disability of mind' it does not mean the person has a mental illness.

It is worth emphasising at this point that there is a strong interrelationship between the *Mental Health Act* and the *Guardianship and Administration Act*. The role of the Guardianship Board in overseeing the care and treatment of people with

a mental illness has already been referred to. Further, the *Guardianship and Administration Act* defines 'mental incapacity' as:

> … the inability of a person to look after his or her own health, safety or welfare or to manage his or her own affairs, as a result of—
>
> a) any damage to, or any illness, disorder, imperfect or delayed development, impairment or deterioration, of the brain or mind; or
>
> b) any physical illness or condition that renders the person unable to communicate his or her intentions or wishes in any manner whatsoever.

Such a definition could include persons with a mental illness as well as persons with an intellectual disability and persons with senile dementia.

ADMISSION TO AND DETENTION IN AN APPROVED TREATMENT CENTRE

The *Mental Health Act* refers to what is known as an 'approved treatment centre' as the place where treatment is provided and where persons may be detained. Section 3 provides that an 'approved treatment centre' is any place determined by the minister under Part 12 Division 5 of the Act. In that Division, section 96 states that in determining a place to be an approved treatment centre, the minister may attach such conditions or limitations to the decision and may vary or revoke a determination made. Similarly, in section 97, the minister may determine a place to be 'a limited treatment centre' and may vary or revoke such a determination.

Where the expression 'treatment centre' is used in the Act it means an 'approved treatment centre' or a 'limited treatment centre'.

Persons admitted to, or treated at, an approved treatment centre fall under one of two categories — voluntary or involuntary.

Voluntary admission and treatment

Section 8 of the Act provides that a person may be admitted as a patient to a treatment centre at his or her own request and may leave that treatment centre at any time unless a detention and treatment order applies.

As soon as practicable after admission, a voluntary patient must be given a written statement of rights (s 9). As well, a copy must be given to the patient's guardian, medical agent, relative, carer or friend.

A written treatment and care plan must be formulated for the patient, preferably in consultation with the patient or guardian, medical agent, relative, carer or friend. The plan must describe the treatment and care that will be provided including rehabilitation and other services to be provided after discharge (s 39).

Involuntary admission and treatment

Power to apprehend and restrain a person for examination

The Act gives power to members of the police force and to authorised officers under the Act to apprehend persons who appear to be suffering from a mental illness (ss 56 and 57). Where an authorised officer or a member of the police force has reasonable cause to believe that a person has a mental illness and the person has caused harm, or there is a significant risk of the person causing harm to himself or herself or to others, the police officer or authorised officer may enter any place to

apprehend and restrain the person using such force as is reasonably necessary in the circumstances and take him or her as soon as practicable to a treatment centre for examination.

As defined in section 3, an 'authorised officer' is a mental health clinician, an ambulance officer, a person employed as a medical officer or flight nurse employed by the Royal Flying Doctor Service Central Operations or South Eastern section, or a person of a class identified in the Regulations of the Act.

A 'mental health clinician' is defined as a person engaged in the treatment or care of patients and classified by the Chief Psychiatrist as a mental health clinician for the purposes of the Act.

The Act provides for treatment to be given on an involuntary basis either in the community by the making of a community treatment order (CTO) or in detention by the making of a detention and treatment order (DTO).

Community treatment orders

There are two levels of community treatment orders. A level 1 CTO may be made by a medical practitioner or authorised health professional (s 10) if it appears:

- the person has a mental illness; and
- the person requires treatment for his or her protection and the protection of others; and
- there are facilities and services available; and
- there is no less restrictive means available than a CTO for the person's illness.

Reference to an 'authorised health professional' above is defined as a person or specified class of persons as determined by the minister (Pt 12 Div 4). Registered nurses and other healthcare professionals would fall into this category.

When a decision is made to make a level 1 CTO, consideration must be given to having the person receive the treatment on a voluntary basis (s 10(2)).

A level 1 CTO must be in writing and expires 28 days after the order is made (s 10(3) and (4)). If a level 1 CTO is not made by a psychiatrist or an authorised medical practitioner, one of them must examine the patient within 24 hours of the order being made, or as soon as practicable. On completion of the examination the psychiatrist or authorised medical practitioner may confirm the level 1 CTO or revoke it.

Once a level 1 CTO is confirmed or revoked by the psychiatrist or authorised medical practitioner, the Guardianship Board (the board) and the Chief Psychiatrist must be notified in writing within one business day of the order being made or revoked (s 11). A copy of the order must be given to the patient as soon as practicable as well as a statement of rights in a language or manner the patient can comprehend (s 12). A copy must also be given to the patient's guardian, medical agent, relative, carer or friend as appropriate (s 12).

Where a level 1 CTO is made, treatment authorised by a psychiatrist or an authorised medical practitioner who has examined the patient may be given despite the patient's refusal to, or absence of, consent (s 13). Treatment may also be given without authorisation in an emergency if a medical practitioner considers the

treatment is needed for the patient's wellbeing and authorisation is not readily obtainable (s 13).

The board is required to review a level 1 CTO as soon as practicable after notification. On review, the board may revoke the order or make a level 2 CTO (s 15).

A level 2 CTO may be made by the board based on the same criteria required to be considered in the making of a level 1 CTO (s 16). Again, as with a level 1 CTO, consideration must be given to the person receiving treatment on a voluntary basis.

A level 2 CTO may be made by the board:

- on a review of a level 1 CTO;
- on an application for revocation of a level 3 detention and treatment order;
- on an application made to the board whether or not a level 1 CTO is in place.

An application to the board for a level 2 CTO may be made by:

- the Public Advocate;
- an authorised medical practitioner;
- a mental health clinician;
- the guardian, medical agent, relative, carer or friend of the person who is the subject of the application;
- any other person who the board is satisfied has a proper interest in the patient's welfare.

A level 2 CTO expires 6 months after it is made in relation to a child and 12 months in all other cases.

Where a level 2 CTO is made, treatment may be authorised by a psychiatrist or authorised medical practitioner who has examined the patient despite the patient's refusal to, or absence of, consent. Where a level 2 CTO is in place, a treatment and care plan must be made (s 40). The plan must detail the treatment to be provided to the patient including rehabilitation and other services whether on an involuntary basis or through the patient's voluntary participation. As far as is practicable, the patient's guardian, medical agent, relative, carer or friend is to be consulted in preparing and revising the treatment and care plan.

Detention and treatment orders

The making of a detention and treatment order (DTO) is the process by which a person may be involuntarily detained and treated in a treatment centre. Three levels of DTOs may be made. In each case the criteria for making an order is the same:

- the person has a mental illness; and
- the person requires treatment for his or her own protection and the protection of others from harm; and
- there is no less restrictive means of treatment other than detention and treatment in an approved treatment centre.

In making or reviewing a DTO, irrespective of the level of the order being made or reviewed, consideration must be given as to whether the treatment is able to be given on a voluntary basis or by compliance with a CTO. As well, if a person refused or failed to comply with a CTO may be a relevant consideration in making a DTO (s 20).

The three levels of DTOs able to be made under the Act are summarised as follows:

1) A level 1 DTO may be made by a medical practitioner or an authorised health professional who, having examined the person, is of the opinion that the person fulfills the criteria for admission as an involuntary patient (as described above) and may order that the person be detained and treated as an involuntary patient. A level 1 DTO is valid for 7 days. The patient must then be examined by a psychiatrist or an authorised medical practitioner (though not the person who made the initial order) within 24 hours of the order being made, or as soon as practicable. Following that examination, the psychiatrist or authorised medical practitioner may confirm or revoke the level 1 DTO or substitute it with a CTO (s 21).
2) Where a level 1 DTO is made or confirmed by a psychiatrist or an authorised medical practitioner, they may, after a further examination of the patient and before the level 1 order expires, make a further order, known as a level 2 DTO. A level 2 DTO expires after 42 days. During that time the psychiatrist or authorised medical practitioner may revoke the level 2 DTO at any time and may substitute it with a CTO (s 25).
3) A level 3 DTO is made by the board. In making the order, the board must be satisfied that the person fulfills the criteria for admission as an involuntary patient (as described above). The board may make an order even though a level 2 or level 3 DTO already applies to the person. An application for a level 3 DTO may be made by the Public Advocate, the director of an approved treatment centre or an employee of an approved treatment centre authorised to do so. The board may revoke or vary a level 3 DTO at any time. If it revokes a level 3 DTO it may substitute it with a level 2 CTO. An application to revoke or vary a level 3 DTO may be made by the Public Advocate, a medical practitioner, a mental health clinician, guardian, medical agent, relative, carer or friend of the patient, or any other person who the board is satisfied has a proper interest in the patient's wellbeing. A level 3 DTO expires 6 months after it is made with respect to a child and 12 months for all other persons (s 29).

Where a patient is detained pursuant to a level 1, level 2 or level 3 DTO, he or she may be given treatment authorised by a medical practitioner without consent. Where a patient is being detained and treated on a level 2 or level 3 DTO, a treatment and care plan must be in place (s 41). The treatment plan must describe the treatment and care to be given including rehabilitation and other services on discharge. As far as is practicable, the patient should be consulted in the preparation and revision of a treatment and care plan as well as the patient's guardian, medical agent, relative, carer or friend of the patient.

GUARDIANSHIP BOARD

The Guardianship Board set up under the *Guardianship and Administration Act 1993* is charged with the responsibility of being the legal guardian of persons under its own Act as well as its responsibilities under the provisions of the *Mental Health Act 2009*. In carrying out that latter role, the Guardianship Board is given power to make decisions about the review of detention orders, care, treatment, education and other matters relating to people with a mental illness.

The provisions for the setting up, the composition, the procedural powers and the powers of the board in relation to its guardianship role are all set out in the *Guardianship and Administration Act*. However, the role of the board in making and reviewing community treatment orders and detention and treatment orders for persons with a mental illness are set out in Part 11 of the *Mental Health Act*, specifically sections 79 to 85.

As provided in section 79 of the Act, the board must review community treatment orders and detention and treatment orders made, specifically level 1 and level 2 CTOs and level 1 and level 3 DTOs. In carrying out its role, the board may conduct any review it considers appropriate and in any manner it considers appropriate.

In completing a review, the board must revoke any order if it is not satisfied there are proper grounds for it to remain (s 80). In reviewing orders the board may affirm, vary or revoke an order or make an order not being a DTO if the board considers it should be made in relation to the person including a treatment and care plan.

Electroconvulsive therapy (ECT)

The Act allows for electroconvulsive therapy (ECT) to be undertaken in accordance with the criteria set out in section 42, as follows:

- the patient has a mental illness; and
- ECT or a course of ECT has been authorised by a psychiatrist who has examined the patient; and
- written consent is given by the patient or on behalf of the patient, *or* if the patient is under 16 years of age, by the board on the application of a mental health practitioner or medical practitioner.

Any consent that is given is limited to a maximum of 12 doses of ECT given over a maximum period of 3 months. Any subsequent course of ECT requires a further written consent.

ECT may be given without consent if it is considered to be urgently required for the patient's wellbeing and it is not practicable to obtain consent. If that occurs, the Chief Psychiatrist must be notified within one business day of the administration of the ECT. A failure to do that is considered an offence subject to a maximum penalty of $50 000 or 4 years' imprisonment.

Neurosurgery

Neurosurgery is defined in section 3 of the Act as a leucotomy, amygdaloidotomy, hypothalomotomy, temporal lobectomy, cingulectomy, electrode implantation in the brain or any other brain surgery for the relief of mental illness by the

elimination or stimulation of apparently normal brain tissues. Such surgery is permitted (s 43) where:

- the patient has a mental illness; and
- the neurosurgery is authorised as treatment by the person who is to carry out the procedure *and* by two psychiatrists who have each separately examined the patient; and
- if the patient is capable of giving effective consent, he or she has given written consent; or
- if the patient is over 16 years of age and effective written consent has been given by the patient; or
- if the patient is not capable of giving effective consent, by the board on application by a medical practitioner or mental health clinician.

A failure to abide by the provisions of the Act is considered an offence with a maximum penalty of $50 000 or 4 years' imprisonment.

Section 44 provides that 'other prescribed psychiatric treatments' (other than ECT or neurosurgery) that may be undertaken are to be provided for in the Regulations that accompany the Act.

PATIENT RIGHTS, REVIEW OF CARE AND APPEAL MECHANISMS UNDER THE ACT

Those objectives and principles of the Act already detailed above are reinforced by the mandatory requirement that all patients be given a written statement of his or her rights under the Act and that a copy also be given to the patient's guardian, medical agent, relative, carer or friend. (See, for example, s 9 on voluntary patients, s 12 on level 1 CTOs, s 23 on level 1 DTOs and s 27 on level 2 DTOs where the requirement for a written statement of rights to be given is prescribed.) If a patient is illiterate, or too disturbed to read and comprehend the statement, steps must be taken as may be practicable in the circumstances to convey the information contained in the statement to the patient.

Additionally, patients must, as far as is practicable, be consulted in the preparation and revision of his or her treatment and care plan as well as the patient's guardian, medical agent, relative, carer or friend.

The rights of patients and the protection afforded to them under the Act are further reinforced in Part 8 Division 1 (ss 45–49). Those sections:

- require an interpreter to be provided where a person being examined cannot communicate adequately in English (s 45);
- require copies of board decisions or orders relating to the patient be given to him or her (as well as the patient's guardian etc) including a statement of the patient's legal rights (s 46);
- reaffirm a patient's right to have another person for support wherever practicable (s 47);
- prescribe a patient's right to communicate with persons outside a treatment centre, to receive visitors and be afforded reasonable privacy in communicating with others (s 48);

- prescribe that any ill treatment or wilful neglect of a patient by a person having care and control of the person is an offence with a maximum penalty of $25 000 or 2 years' imprisonment (s 49).

Part 2 Division 3 of the *Guardianship and Administration Act 1993* (ss 18–24) creates the office of Public Advocate. That position has a general and wide-ranging overseeing and advocacy role in relation to mentally incapacitated persons. Because of the definition of 'mental incapacity' in the *Guardianship and Administration Act*, that would include a significant number of mentally ill people.

COMMUNITY VISITORS

Part 8 Division 2 (ss 50–54), which established this scheme, commenced in June 2011. The governor appoints the positions of the principal community visitor and community visitors.

The functions of community visitors are to:

- conduct visits to, and inspect, treatment centres — every month, two or more community visitors must conduct such visits (s 52); and
- refer matters of concern relating to the delivery of mental health services or the care and control of patients to the minister, Chief Psychiatrist or other appropriate body (s 51); and
- act as advocates for patients to assist in the resolution of issues relating to their care and treatment (s 51); and
- any other functions assigned by the Act (s 51).

In visiting treatment centres, community visitors must, as far as practicable, inspect all parts of the centre and make inquiries about care, treatment and control of patients being detained or treated. Following such inspections, a report must be made to the principal community visitor.

Community visitors may visit treatment centres at any time of the day or night, with or without notice (s 52). A visit may be requested by a patient or by the patient's guardian, medical agent, relative, carer or friend who may also wish to speak to a community visitor (s 53).

The principal community visitor is required to report to the minister on or before 30 September each year and the report must be tabled in Parliament (s 54).

APPEAL RIGHTS

There is a right of appeal to the Guardianship Board if there is dissatisfaction with a CTO or a DTO (s 81). The board may dismiss, affirm, vary or revoke the order. While awaiting appeal the order continues to operate (s 82). Persons appealing to the board are entitled to legal representation (s 84).

Decisions of the Guardianship Board may be reviewed by way of appeal to the Administrative and Disciplinary Division of the District Court and then to the Supreme Court of South Australia (Part 11 Division 2 ss 81–85).

Tasmania: *Mental Health Act 1996*

The *Mental Health Act 1996* is under review. Section 6 states the objects of the Act as being:

a) with mental illnesses in accordance with the best possible standards while at the same time safeguarding and maintaining their civil rights and identity; and
b) to ensure that involuntary patients, forensic patients and persons subject to supervision orders or community treatment orders who have mental illnesses are provided with appropriate information about their statutory and other rights; and
c) to provide for the making and review of orders for the involuntary admission, treatment and detention of involuntary patients with mental illnesses; and
ca) to provide for the authorising of medical treatment by the Forensic Tribunal; and
d) to provide for the monitoring and review of the mental health system; and
e) to ensure that the services provided for persons with mental illnesses are equitable, comprehensive, coordinated, accessible and free from stigma and in particular to ensure that standards of care and treatment for those persons are at least equal to the standards of care and treatment for physical illnesses and disabilities; and
f) to promote recognition in the community of the right of persons with mental illnesses to the best possible standards of care and treatment; and
g) to ensure that all practicable measures are taken to prevent mental illness or to arrest or impede its progress at an early stage; and
h) to reduce the adverse effects of mental illness on family life; and
i) to encourage and contribute to the highest possible standards of –
   i) care and treatment for persons with mental illnesses; and
   ii) research into the causes of, and treatment for, mental illnesses; and
j) to encourage the care and treatment of persons with mental illnesses in the community and to design and coordinate an integrated system of community support services for persons with mental illnesses who are being cared for in the community; and
k) to ensure that, in relation to patients, all appropriate measures are taken to protect the safety of the patients and other persons.

DEFINITIONS

Section 3 of the Act contains relevant definitions, however, section 4 defines 'mental illness' as follows:

1) A mental illness is a mental condition resulting in –
   a) serious distortion of perception or thought; or
   b) serious impairment or disturbance of the capacity for rational thought; or
   c) serious mood disorder; or
   d) involuntary behaviour or serious impairment of the capacity to control behaviour.

2) A diagnosis of mental illness may not be based solely on –
   a) antisocial behaviour; or
   b) intellectual or behavioural nonconformity; or
   c) intellectual disability; or
   d) intoxication by reason of alcohol or a drug.

The care of persons who do not have a mental illness as defined above but who have a 'disability' comes under the *Guardianship and Administration Act 1995* (Tas) and specifically the Guardianship and Administration Board. A person with a disability may have a mental illness. Where that occurs the *Mental Health Act* takes precedence but where consent is required for treatment under the *Mental Health Act* for a person under guardianship, the person's guardian must give consent on the person's behalf. For some people that will be the Guardianship and Administration Board.

For the purposes of the Act, an approved hospital is defined in section 3 as:

> … a hospital or part of a hospital approved by the Minister for the care and treatment of involuntary patients with mental illnesses.

ADMISSION TO AND DETENTION IN AN APPROVED HOSPITAL

Voluntary admission

The Act makes specific provision for persons to be voluntarily admitted to an approved psychiatric hospital on the basis of his or her mental illness. Section 19 provides:

> A person is a voluntary patient if at the time of admission –
>
> a) the person is of or over the age of 14 years and is admitted to an approved hospital with his or her consent; or
>
> b) the person –
>
> i) is under the age of 14 years; and
>
> ii) is admitted to an approved hospital with the consent of his or her parent; and
>
> iii) does not resist admission to the approved hospital.

A medical practitioner at an approved hospital may refuse a request for voluntary admission. If that occurs, reasons must be given as to why the admission is refused and advice must be given to the person regarding alternative sources of treatment (s 20). A second opinion may be requested by the person seeking admission if the initial request is refused (s 21).

A voluntary patient may discharge himself or herself from an approved hospital subject to the provisions of section 23 (s 22). Where a voluntary patient seeks discharge from an approved hospital, a medical practitioner or an approved nurse may take the person into protective custody and detain the person for assessment as to whether the person should be detained as an involuntary patient. The person can be held for 4 hours for the examination to take place. If no order for involuntary detention is made in that time, the person must be released (s 23).

Involuntary admission

In section 24 the criteria for detaining a person in an approved hospital as an involuntary patient are that:

a) the person appears to have a mental illness; and
b) there is, in consequence, a significant risk of harm to the person or others; and
c) the detention of the person as an involuntary patient is necessary to protect the person or others; and
d) the approved hospital is properly equipped and staffed for the care or treatment of the person.

An application for the involuntary admission and detention of a person as an involuntary patient may be made by an authorised officer or the person responsible for the patient (s 25). An authorised officer includes a police sergeant or a police officer in charge of police stations. The phrase 'person responsible' is defined in section 5 as follows:

1) In this Act, person responsible for another person means –
   a) where the other person is under 18 years and has a spouse, the spouse; or
   b) where the other person is under 18 years and has no spouse, his or her parent; or
   c) where the other person is of or over the age of 18 years, one of the following persons in order of priority:
      i) his or her guardian;
      ii) his or her spouse;
      iii) the person having the care of the other person;
      iv) a close friend or relative of the other person.

Initial assessment

Police officers or authorised persons may, under section 15, take a person into protective custody for assessment if they consider on reasonable grounds that:

- the person has a mental illness; and
- there is, in consequence, a serious risk of harm to the person or to others.

To take a person into protective custody, an authorised officer may enter premises without a warrant. Police assistance may be requested and reasonable force may be used to take the person into protective custody (s 15). Where that occurs, the person must be taken to an assessment centre (generally an authorised hospital) as soon as possible. The assessment centre must be notified within 2 hours of the person being taken into custody. Once at the assessment centre the person may be detained for 4 hours for assessment. If assessment is not done within that time, the person is to be discharged (s 16).

Admission to an approved hospital after assessment

Any person may be admitted as a patient to an approved hospital if over the age of 14 years with the consent of the person, or under an initial order, a community

care order or authorisation for temporary admission (s 17). Voluntary admission is to be preferred to involuntary admission wherever possible (s 18).

A medical practitioner, who is satisfied that the criteria for the detention of a person as an involuntary patient are met (as defined under s 24 above), may make an initial order for the admission and detention of that person as an involuntary patient in an approved hospital (s 26).

An initial order to detain a person must be confirmed by a second approved medical practitioner within 24 hours or it ceases to have effect (s 27). Alternatively a community treatment order or continuing care order (CCO) must be made within 72 hours of the initial order or the initial order becomes ineffective (s 27).

Continuing care order

To continue to detain a person as an involuntary patient after the initial order is made, a continuing care order (CCO) must be made (s 28). Any such order must be signed by two medical practitioners, one of whom is an approved medical practitioner, who have each personally examined the patient and are satisfied that the criteria for detention as an involuntary patient are met. The medical practitioner who made the initial order may not sign the CCO. The CCO is required to include a statement confirming the matters set out in section 24 detailed above; that is, that the person is mentally ill and poses a risk of harm to himself or herself or to others (s 28).

If the patient is not in the hospital in which he or she is to be detained under the CCO, an authorised officer may take the person to the other hospital (s 28).

Section 29 sets out the conditions of a CCO and how it may be renewed and the circumstances in which it ceases to have effect in the following terms:

1) A continuing care order operates for a term, not exceeding 6 months, stated in the order but may be renewed from time to time by 2 approved medical practitioners who have each separately examined the patient, within a month before the end of the period for which the order was made or last renewed, and have satisfied themselves that the criteria for detention as an involuntary patient in an approved hospital continue to be met.
2) A continuing care order ceases to have effect if –
   a) the senior approved medical practitioner of the approved hospital in which the patient is detained discharges the order; or
   b) the Mental Health Tribunal, on review of the order, discharges the order; or
   c) a community treatment order for the patient is made; or
   d) the order is not renewed or further renewed at the end of the term for which the order was made or last renewed; or.
   e) the patient becomes a forensic patient.

The Mental Health Tribunal is required to be notified in writing within 48 hours of a person's admission to an approved hospital under a CCO. That notification is required to be updated on a weekly basis providing details of the discharge or transfer of involuntary patients during the previous week (s 70).

Community treatment order

As the name implies, a community treatment order (CTO) may be made to allow for a person with a mental illness to be treated in the community instead of in an approved hospital. Section 40 sets out the criteria for making a CTO as follows:

> A community treatment order may be made for the treatment of a person only if –
>
> a) the person has a mental illness; and
>
> b) there is, in consequence, a significant risk of harm to the person or others unless the mental illness is treated; and
>
> c) the order is necessary to ensure that the illness is properly treated; and
>
> d) facilities or services are available for the care and treatment of the person.

A CTO may be made by two approved medical practitioners who have each separately and within the previous 7 days examined the patient (s 41).

A CTO must specify the requirements of section 42. The requirements of a patient under a CTO are expressed in section 43; that is, that a CTO may:

- require the patient to take or submit to the administration of medical treatment as specified by the order or as decided by a medical practitioner nominated in the order; or
- require the patient to attend as an outpatient at a nominated treatment centre at specified intervals or as directed by a medical practitioner nominated in the order; or
- require the patient to comply with other requirements specified in the order or to be specified by a person nominated in the order.

A CTO may remain in force for a period not exceeding 12 months (s 44(1)). It may be renewed from time to time by two approved medical practitioners who, within a month before the end of the term for which the order was granted or last renewed, have each separately examined the patient (s 44(2)).

If a person under a CTO is admitted as a voluntary patient to an approved hospital, the CTO is suspended until the person is discharged and then revived (s 44(3)). Likewise, if a person under a CTO is admitted as an involuntary patient, either for temporary admission or otherwise, the CTO is suspended until the patient is discharged. It is then reactivated unless it has ceased to have effect as provided (s 44(3A) and (3B)). Obviously, while suspended, a CTO has no effect (s 44(3C)).

As provided by section 44(4), a CTO ceases to have effect if:

- one of the approved medical practitioners who made the order discharges the order; or
- the Mental Health Tribunal, on review of the order, discharges the order; or
- the community treatment order is not renewed, or further renewed, at the end of the term for which the order was made or last renewed; or
- the patient remains in an approved hospital as a patient for 3 months; or

- the authorisation for temporary admission ends under section 44C(e) because the person has been admitted to an approved hospital as an involuntary patient in excess of 14 days.

Section 44A(1) allows an approved medical practitioner to authorise the temporary admission of a person to whom a CTO applies as an involuntary patient to an approved hospital if the medical practitioner and either an authorised officer or a person responsible are both satisfied that:

- the patient has failed to comply with the order; and
- all reasonable steps have been taken to obtain the cooperation of the patient in complying with the order; and
- the health of the patient has deteriorated, or there is a significant risk that the health of the patient will deteriorate, because of the patient's failure to comply with the order.

Once authorisation is given for temporary admission, it permits the person to be detained in an approved hospital for a period not exceeding 14 days (s 44B). That authority for temporary admission ends when, as provided in section 44C, one of the following occurs:

- the approved medical practitioner who made the authorisation cancels it;
- the elapse of the period of 28 days commencing on the day on which the authorisation is made, unless the patient is admitted to an approved hospital on the authority of the authorisation within that period;
- after the patient is admitted to an approved hospital as an involuntary patient on the authority of the authorisation, the patient is discharged from the hospital by the medical practitioner who is in charge of his or her care and treatment;
- after the patient is admitted to an approved hospital as an involuntary patient on the authority of the authorisation, a continuing care order is made in respect of the patient;
- the elapse of the period of 14 days commencing on the admission of the patient to an approved hospital as an involuntary patient on the authority of the authorisation;
- the community treatment order to which the authorisation relates ceases to have effect under section 44(4)(a), (b) or (c);
- the tribunal, on review of the authorisation, discharges the authorisation.

THE ROLE OF THE MENTAL HEALTH TRIBUNAL

Section 48 of the Act provides for the setting up of the Mental Health Tribunal. Section 48 and Schedule 1 of the Act deal with the appointment, composition and chairpersonship of the tribunal.

Section 51 sets out the functions of the tribunal as follows:

- to review decisions and orders to admit persons as involuntary patients in approved hospitals; and

- to carry out periodic reviews of the detention of involuntary patients in approved hospitals; and
- to review the making of, and carry out periodic reviews of, CTOs; and
- to receive reports on the use of restraint, seclusion and the withholding of information under section 45(3) and, if thought fit, to issue directions or guidelines for regulating any such matters; and
- to review a decision to admit an involuntary patient to a secure mental health unit under section 72B; and
- to carry out the other functions conferred on the tribunal under the *Mental Health Act* or any other Act.

As well, section 52 provides that the Mental Health Tribunal must review:

- a CCO or a CTO within 28 days after the date when the order is made or renewed;
- a transfer of an involuntary patient to Tasmania within 28 days after the date on which the patient is transferred;
- the admission of an involuntary patient to a secure mental health unit under section 72B within 3 days of the patient being admitted;
- in addition to the mandatory review required in all of the above matters, the tribunal must review any order made on an application by the patient, a person responsible for the patient or another person who has, in the opinion of the tribunal, a proper interest in the patient's welfare.

The powers of the tribunal under section 65 in undertaking a review of a decision and authorisation for temporary admission, or order, are that the tribunal may:

- confirm or vary the decision, authorisation or order, or revoke the decision, authorisation or order and substitute a different decision, authorisation or order; and
- give such directions as are necessary to ensure compliance with the tribunal's determination; and
- give other directions the tribunal considers necessary or desirable in the interests of the person to whom the decision, authorisation or order relates (s 65).

FORENSIC TRIBUNAL

The creation of the Forensic Tribunal was a result of amendments made to the Act in 2005. The Forensic Tribunal is intended to deal with persons who come before the courts having committed a criminal offence and who have an underlying mental health pathology. That factor may well be crucial as to how such a person — generally known as a 'forensic patient' — will be dealt with by the courts. Under the Act, a forensic patient is a person who has been admitted to a secure mental health unit and who has not been discharged from such a unit.

FORMS AND TYPES OF TREATMENT UNDER THE ACT

Care and treatment orders

The provisions that apply to the making of an initial order, community care orders and community treatment orders have been detailed earlier in this section.

Medical treatment

There is no definition as to what constitutes 'medical treatment' in the Act. Section 31 allows medical treatment to be administered to a patient with the patient's informed consent, or, where necessary, the authority of the Guardianship and Administration Board. There are, however, some limitations placed on what constitutes medical treatment, in that section 32 states that medical treatment does *not* include sterilisation, termination of pregnancy or removal of non-regenerative tissue for transplantation. Section 32 also provides for the Guardianship and Administration Board to consent to medical treatment on behalf of a patient who is unable or unwilling to consent and requires the treatment for his or her mental illness. As well, section 32 provides that medical treatment may be given notwithstanding the patient's inability or refusal to consent.

The meaning of 'informed consent' for the purposes of the Act is defined in section 5AA as follows:

1) A person is taken to have given informed consent to proposed medical treatment if, and only if, the following requirements are satisfied:
   a) the person is, in the opinion of the medical practitioner who is responsible for administering the proposed treatment, mentally capable of understanding the general nature and effect of the proposed treatment;
   b) the person, after being given the information required under subsection (2), freely and voluntarily consents to the proposed treatment;
   c) the person has not withdrawn the consent.
2) The medical practitioner who is responsible for the administration of medical treatment to a person must give the person whose consent to medical treatment is sought:
   a) a clear explanation of the proposed treatment; and
   b) a description, without concealment or distortion, of the benefits and disadvantages of the treatment, including a statement of the risk of adverse consequences; and
   c) a description of alternative forms of treatment that may be available and their benefits and disadvantages; and
   d) clear answers to questions asked by the person; and
   e) a reasonable opportunity to obtain independent medical or other advice.

Electroconvulsive therapy (ECT) and psychosurgery

No specific reference or regulation is included in the Tasmanian Act to ECT or psychosurgery. As it is not a medical treatment excluded by section 32, the patient or the board could authorise such treatment subject to the provisions of that section.

Physical restraint

Physical restraint may be applied only if the restraint (s 34):

- is necessary:
  - for medical treatment of the patient; or
  - to prevent injury to the patient or to others; or
  - to prevent the patient from persistently destroying property; and
- is authorised by a medical practitioner or an approved psychiatric nurse for a period of less than 4 hours; and
- is applied for no longer than authorised or if the restraint is in accordance with guidelines issued by the tribunal.

Seclusion

Seclusion is permissible only if (s 35):

- the seclusion is necessary for the protection of the patient or other persons with whom the patient would otherwise be in contact; and
- the seclusion is authorised by a medical practitioner or an approved psychiatric nurse; and
- the patient is kept in seclusion for no longer than authorised.

Where a patient is kept in seclusion, he or she must (s 35):

- be visited by a member of the nursing staff at intervals of no more than 15 minutes or in accordance with guidelines issued by the Mental Health Tribunal; and
- be examined at intervals of no more than 4 hours by a medical practitioner; and
- be provided with bedding and clothing that is appropriate in the circumstances; and
- be provided with food and drink at the appropriate times; and
- have access to adequate toilet arrangements.

Monthly reports must be submitted to the tribunal where seclusion or restraint is administered to an involuntary patient in an approved hospital (s 36).

PATIENT RIGHTS AND THE ROLE OF OFFICIAL VISITORS UNDER THE ACT

Section 45 of the Act requires involuntary patients to be given a statement of their legal rights as well as information about advocacy services and grievance procedures. A copy of such a document must also be given to the patient's nominated 'person responsible'.

OFFICIAL VISITORS

The Act provides for the appointment of official visitors who are required to visit approved hospitals at least once a month.

The functions of the official visitor are (s 75):

- to examine the adequacy of services for the assessment and treatment of mental illnesses;
- to examine the appropriateness and standard of the facilities for the accommodation, assessment, care and treatment of persons with a mental illness;
- to examine the facilities for the recreation, occupation, education, training and rehabilitation of persons receiving care or treatment for mental illness;
- to investigate any suspected contravention of the Act in the care or treatment of persons with a mental illness, particularly unnecessary bodily restraint, seclusion or other restriction on freedom;
- to visit patients and assess the adequacy of their care and treatment; and
- to investigate complaints made by persons receiving care or treatment.

Section 79 of the Act requires that an official visitor must report to the Mental Health Tribunal or the Forensic Tribunal if he or she suspects on reasonable grounds a contravention of the Act in relation to the care or treatment of a patient with a mental illness.

Victoria: *Mental Health Act 1986*

PROPOSED NEW MENTAL HEALTH ACT FOR VICTORIA

In 2010, the then Victorian Government released a document titled 'Exposure Draft Mental Health Bill 2010: Explanatory Guide'.[12] That document sets out what were intended to be the main features of a new *Mental Health Act* for Victoria. The purpose of the Exposure Draft was to elicit feedback from stakeholders and the community about a proposed new *Mental Health Act*. The intention was that, after considering the feedback from the Exposure Draft Bill, the government would introduce a new Mental Health Bill into Parliament in 2011 which, once passed by Parliament and proclaimed, would commence as an Act in mid 2012. All of the proposed timelines were stated to be 'subject to the outcome of the November 2010 Victorian election'.

That election saw a change of government in Victoria. As a result, the proposed timeline for the proposed new *Mental Health Act* for Victoria has been considerably delayed. At the time of writing it is unclear as to when a new *Mental Health Act* for Victoria will be finalised. Until any new Act is proclaimed, the *Mental Health Act 1986* (as amended from time to time) will continue to operate as the relevant mental health legislation in Victoria.

Mental Health Act 1986

DEFINITIONS

A definition of mental illness was introduced into section 8 of the Act in 1995 and provides that a person is mentally ill if he or she has a mental illness 'being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory' (s 8(1A)).

In Victoria a mental disorder includes mental illness (s 3). Like New South Wales, the Victorian mental health legislation seeks to exclude persons with intellectual disabilities from the provisions of the *Mental Health Act*.

There is currently no specific provision in the Act for voluntary mentally ill persons. Section 8(1) provides the following criteria for the involuntary treatment of a person:

> a) the person appears to be mentally ill; *and*
> b) the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order; *and*
> c) because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; *and*
> d) the person has refused or is unable to consent to the necessary treatment for the mental illness; *and*
> e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action. [emphasis added]

In relation to paragraph (d) above where the 'person has refused or is unable to consent' to treatment, it is important to bear in mind that it is only the 'person's' refusal or inability to consent that is relevant here — not that of the person's legal guardian or person responsible under the *Guardianship and Administration Act 1986* (Vic) or agent under the *Medical Treatment Act 1988* (Vic) (s 3A).

The *Mental Health Act* also makes provision similar to that of the New South Wales Act for conduct which is *not* to be considered to be mentally ill; section 8(2) and (3) set out as follows:

> 2) A person is not to be considered to be mentally ill by reason only for any one or more of the following—
> a) that the person expresses or refuses or fails to express a particular political opinion or belief;
> b) that the person expresses or refuses or fails to express a particular religious opinion or belief;
> c) that the person expresses or refuses or fails to express a particular philosophy;
> d) that the person expresses or refuses or fails to express a particular sexual preference or sexual orientation;
> e) that the person engages in or refuses or fails to engage in a particular political activity;
> f) that the person engages in or refuses or fails to engage in a particular religious activity;
> g) that the person engages in sexual promiscuity;
> h) that the person engages in immoral conduct;

i) that the person engages in illegal conduct;
j) that the person is intellectually disabled;
k) that the person takes drugs or alcohol;
l) that the person has an antisocial personality;
m) that the person has a particular economic or social status or is a member of a particular cultural or racial group.

3) Subsection (2)(k) does not prevent the serious temporary or permanent physiological, biochemical or psychological effects of drug or alcohol taking from being regarded as an indication that a person is mentally ill.

ADMISSION TO AND DETENTION IN AN APPROVED MENTAL HEALTH SERVICE

The Act makes provision in section 94 for any premises or service where, or through which, treatment is to be provided to be declared an approved mental health service.

VOLUNTARY ADMISSIONS OR TREATMENT

Unlike New South Wales, the Victorian Act makes no provision for voluntary admission or treatment.

INVOLUNTARY ADMISSION OR TREATMENT

The Act emphasises a request or recommendation for involuntary treatment (s 9), the process of which applies to a person who may receive treatment in the community or while detained in approved mental health services.

A request for involuntary treatment must be made in a prescribed form and may be made by a relative or friend who believes, in the best interests of the person, that he or she should receive treatment for a mental illness. The request must be accompanied by a recommendation made by a medical practitioner who is satisfied that the person meets one of the criteria specified in section 8(1) of the Act and that an involuntary treatment order (ITO) should be made (s 9(3)). A medical practitioner who makes such a recommendation must satisfy the provisions of section 123 as to the facts upon which he or she relies in making the recommendation:

1) A registered medical practitioner who signs any recommendation or certificate in connection with the making of an involuntary treatment order or the admission of any person to an approved mental health service must—
   a) specify the facts upon which the opinion that the person to whom the recommendation or certificate relates is mentally ill is based; *and*
   b) distinguish the facts personally observed from—
      i) facts not personally observed; *and*
      ii) facts communicated to the medical practitioner by any other person.
2) A person may be made subject to an involuntary treatment order or be admitted to an approved mental health service on a recommendation or certificate which relies upon facts not personally observed by the medical practitioner if the medical practitioner—
   a) has reasonable grounds for relying on those facts; and
   b) has—

i) personally observed some fact which supports the recommendation or certificate; *or*

ii) relied upon facts personally observed by another medical practitioner within 28 days of the recommendation or certificate and communicated directly by that medical practitioner to the medical practitioner signing the recommendation or certificate.

3) If the medical practitioner signing the recommendation or certificate has relied upon the facts of the kind specified in subsection (2)(b)(ii) the recommendation or certificate must specify the name and address of the other medical practitioner. [emphasis added]

Once the request for admission has been received together with the recommendation by a medical practitioner as set out, a police officer, ambulance officer or any other person is then authorised to take the patient to an approved mental health service. If it is necessary to do so 'such assistance as is required and such force as may be reasonably necessary' is able to be used to enter any premises and take the patient to an approved mental health service (s 9B(2)(a)). In addition, such restraint as may be considered necessary and sedation as may be necessary to enable a person to be taken safely to an approved mental health service may be used and administered (s 9B(2)(b) and (3)).

As is the case in the New South Wales Act, a member of the police force may apprehend and detain a person for examination by a medical practitioner if the person has attempted suicide or caused serious harm to another person, himself or herself, *or* is likely to do so, *or* if the person appears mentally ill. As well, a magistrate may, on information received, order the apprehension of a person for the purposes of detention and examination by a registered medical practitioner. Following examination and assessment by a medical practitioner the person may be transported to an approved mental health service or released (ss 10 and 11).

The relevant provisions applying to the making of an involuntary treatment order to enable a person to receive treatment in the community or in an approved mental health service are found in sections 12–12D inclusive and may be summarised as follows:

1) The making of an involuntary treatment order for persons in the community must be made by a registered medical practitioner in the prescribed form (s 12).

2) If such an order is made, it is sufficient authority to admit and detain a person in an approved mental health service until the person is examined by an authorised psychiatrist (s 12).

3) Once a person has been taken to an approved mental health service, a further involuntary treatment order is required to be made by a registered medical practitioner employed by an approved mental health service (s 12AA). That order is sufficient to detain the person until examined by an authorised psychiatrist. Interim medical treatment may be given immediately pursuant to such an order without the person's consent if considered to be in the person's best interests (s 12AB).

4) Once an involuntary treatment order is made, the person must be examined by an authorised psychiatrist, generally as soon as practicable or within 24 hours after the order is made (s 12AC).
5) If the authorised psychiatrist confirms the involuntary treatment order, he or she may make a community treatment order or detain the person in an approved mental health service (s 12AC) as an involuntary patient.
6) Once detained, an involuntary patient is to be given treatment for his or her mental illness. If consent is refused or unable to be given, the authorised psychiatrist may consent on the patient's behalf (s 12AD).
7) Once a person becomes an involuntary patient, any guardian of the person is to be notified (s 12AE).
8) An authorised psychiatrist may apply to the Chief Psychiatrist to continue the detention and treatment of an involuntary patient for a period not exceeding 3 months (s 12A).
9) Once an application is made pursuant to section 12A, two other qualified psychiatrists must examine the person and support the need for continued detention and treatment (s 12B) for a period specified but not exceeding 3 months.
10) If they are not satisfied and refuse to consent, the authorised psychiatrist must discharge the involuntary patient (s 12C).
11) A person may be detained for an unlimited period on the basis that such detention and treatment is renewed every 3 months (s 12C).
12) An involuntary treatment order may be made if a person requires life-sustaining or emergency treatment in a general hospital (s 13).

The continued detention of an involuntary patient must be reviewed by the Mental Health Review Board in accordance with the provisions of section 30 of the Act which states that the board must conduct a review of an involuntary treatment or security order within 8 weeks after the order is made and thereafter at intervals not exceeding 12 months.

It is appropriate at this point to mention the role, function and procedure of the Victorian Mental Health Review Board.

MENTAL HEALTH REVIEW BOARD

The Victorian Mental Health Review Board was established under the *Mental Health Act 1986*. The composition of and certain procedural provisions relating to the board and its sittings are to be found in Schedules 1 and 2 of the Act. The functions of the board are set out in section 22 as follows:

1) The functions of the Board are as follows—
   a) to hear appeals by or on behalf of involuntary patients and security patients;
   b) to review periodically the orders made for involuntary patients and security patients and their treatment plans;
   c) to hear appeals against the refusal of the Chief Psychiatrist to grant special leave to security patients;

ca) to hear appeals against the transfer of involuntary patients and security patients;
d) to review orders for the transfer of involuntary patients to interstate mental health facilities; [there are no paragraphs (e) and (f)]
g) such other functions as are specified in this Act.

2) The Board must in determining any review or appeal have regard primarily to the patient's current mental condition and consider the patient's medical and psychiatric history and social circumstances.
3) In the case of a review or an appeal of a restricted involuntary treatment order or restricted community treatment order, the Board must, in addition to the matters in subsection (2), consider the patient's forensic history.

Like its counterpart in New South Wales, the Victorian Mental Health Review Board attempts a degree of informality in its hearings whilst at the same time acting according to 'equity and good conscience' and 'the rules of natural justice'. It is not bound by the rules or practice as to evidence. Evidence may be given orally or in writing or partly as to both and may be given under oath, by affirmation or by declaration (s 24).

Similar provisions as to legal representation, provision of an interpreter and appearance before the board as provided under the New South Wales Act appear in the Victorian Act (ss 25 and 26).

Appeals to the Mental Health Review Board may be made at any time 'against the detention of a person as an involuntary patient or a security patient' (s 29). The persons who may make such appeals are:

- an involuntary patient;
- a community visitor;
- any person who satisfies the board that he or she has a genuine concern for the patient.

An involuntary patient may initiate an appeal by writing to:

- the executive officer;
- the Chief Psychiatrist;
- a community visitor;
- an authorised psychiatrist;
- the Ombudsman;
- the Health Services Commissioner.

The review of decisions of the board

Section 120(1) of the Act provides that 'a person whose interests are affected by a determination of the Board may apply to the Tribunal for review of the determination'. Reference to the tribunal in section 120 refers to the Victorian Civil and Administrative Tribunal.

There is also provision in the Act for application to be made to the Supreme Court of Victoria where a question of law arises in proceedings before the board.

That application may be made either by the board of its own motion or by any person who is a party to the proceedings (s 118).

FORMS AND TYPES OF TREATMENT UNDER THE ACT

The Act provides for a community treatment order (CTO) to be made. A CTO is defined in section 14(2) as follows:

> A community treatment order is an order requiring the person to obtain treatment for their mental illness while not detained in an approved mental health service.

Once again the emphasis is on appropriate treatment within a community setting rather than an institutional environment. A CTO may be made by an 'authorised psychiatrist' (s 14(1)). In making a CTO the authorised psychiatrist, in accordance with section 14(3):

- must specify the duration of the community treatment order which must not exceed 12 months; and
- may specify where the patient is to live if this is necessary for the treatment of the patient's mental illness.

Sections 14A, 14B and 14C provide respectively for the monitoring, extension and variation of CTOs.

Section 14D provides that an authorised psychiatrist may revoke a CTO if he or she is satisfied on reasonable grounds that the person has failed to comply with the order or is considered no longer suitable for a CTO. Once a CTO is revoked the person is then deemed to be an involuntary patient absent from an approved mental health service without leave (s 14D(3)). The authorised psychiatrist must make reasonable efforts to inform the person that the order has been revoked and that they must return to an approved mental health service. If they fail or refuse to do so, the person can be apprehended by the police or ambulance service who are able to use whatever force is reasonable and necessary to apprehend and convey the patient to an approved mental health service.

If requested to review a CTO the Mental Health Review Board may vary, or revoke, or discharge a person from, a CTO (ss 36–38 inclusive).

Electroconvulsive therapy (ECT)

Sections 72–80 inclusive contain the provisions relating to ECT.

Under section 53B of the Act a person is deemed to have given informed consent to ECT if that person gives consent in writing after complying with the following conditions:

> 1) For the purposes of this Part (other than section 83(2)), a person is to be taken to have given informed consent to the performance on him or her of treatment only if the person gives written consent to that treatment after—
>
> a) the person has been given a clear explanation containing sufficient information to enable him or her to make a balanced judgement; *and*

b) the person has been given an adequate description of benefits, discomforts and risks without exaggeration or concealment; *and*
c) the person has been advised of any beneficial alternative treatments; *and*
d) any relevant questions asked by the person have been answered and the answers have been understood by the person; *and*
e) a full disclosure has been made of any financial relationship between the person seeking informed consent or the registered medical practitioner who proposes to perform the treatment, or both, and the service, hospital or clinic in which it is proposed to perform the treatment; *and*
f) subsections (2) and (3) have been complied with.

2) The person on whom the treatment is to be performed must be given the appropriate prescribed printed statement—
a) advising the person as to his or her legal rights and other entitlements including—
i) the right to obtain legal and medical advice (including a second psychiatric opinion) and to be represented before giving consent; *and*
ii) the right to refuse or withdraw his or her consent and to discontinue all or any part of the treatment at any time; *and*
b) containing any other information relating to the treatment that the Department considers relevant.

3) In addition to the statement, the person must be given an oral explanation of the information contained in the statement and, if he or she appears not to have understood, or to be incapable of understanding, the information contained in the statement, arrangements must be made to convey the information to the person in the language, mode of communication or terms which he or she is most likely to understand.

4) The statement may be printed in different languages so that, whenever possible, a person can be given a copy of the statement in a language with which he or she is familiar.

5) It is the duty of the authorised psychiatrist to ensure that this section is complied with in the approved mental health service. [emphasis added]

It is important to note that the consent provided for under section 53B is the consent of the person, not the person's guardian, a person responsible, an agent or the tribunal (s 3A).

Where a patient is incapable of giving consent to ECT

If a patient is incapable of giving informed consent to ECT it may still be performed if the following provisions of section 73(3) and (4) are satisfied:

3) If a person who is a patient is incapable of giving informed consent the electroconvulsive therapy may be performed if:
a) the authorised psychiatrist has authorised the electroconvulsive therapy proposed to be performed after being satisfied that—
i) the electroconvulsive therapy has clinical merit and is appropriate; *and*

ii) having regard to any benefits, discomforts or risks the electroconvulsive therapy should be performed; *and*
iii) any beneficial alternative treatments have been considered; *and*
iv) unless the electroconvulsive therapy is performed, the patient is likely to suffer a significant deterioration in his or her physical or mental condition; *and*

b) all reasonable efforts have been made to notify the patient's guardian or primary carer of the proposed performance of the electroconvulsive therapy.

4) Informed consent is not necessary if the nature of the mental disorder that a person has is such that the performance of the electroconvulsive therapy is urgently needed. [emphasis added]

If ECT is undertaken on a person who has not given informed consent or does not come within the provisions of subsections (3) and (4) as set out above, the registered medical practitioner who performs the procedure is guilty of an offence under the Act and guilty of professional misconduct (s 73(1) and (2)).

Psychosurgery

For the purposes of the Act 'psychosurgery' is defined in section 54(1) as follows:

a) any surgical technique or procedure by which one or more lesions are created in a person's brain on the same or on separate occasions primarily for the purpose of altering the thoughts, emotions or behaviour of that person; *or*
b) the use of intracerebral electrodes to create one or more lesions in a person's brain on the same or on separate occasions primarily for the purpose of altering the thoughts, emotions or behaviour of that person; *or*
c) the use of intracerebral electrodes to cause stimulation through the electrodes on the same or on separate occasions without creating a lesion in the person's brain for the purpose of influencing or altering the thoughts, emotions or behaviour of that person. [emphasis added]

The Act also goes to some lengths to make it clear that, where reference to 'behaviour' is made in the definition of psychosurgery as set out above, it does not include (s 54(2)):

i) behaviour manifested as part of generalised convulsive or non-convulsive epilepsy; or
ii) behaviour manifested as part of simple or complex partial epilepsy; or
iii) behaviour considered to be secondary to a paroxysmal cerebral dysrhythmia; or
iv) behaviour manifested as a result of a disorder of the basal ganglia; *and*

b) does include behaviour not considered to be secondary to cerebral dysrhythmia. [emphasis added]

Section 53B(1) of the Act states that a person is deemed to have given informed consent for psychosurgery if they give written consent to that treatment after:

a) the person has been given a clear explanation containing sufficient information to enable him or her to make a balanced judgement; and
b) the person has been given an adequate description of benefits, discomforts and risks without exaggeration or concealment; and
c) the person has been advised of any beneficial alternative treatments; and
d) any relevant questions asked by the person have been answered and the answers have been understood by the person; and
e) a full disclosure has been made of any financial relationship between the person seeking informed consent or the registered medical practitioner who proposes to perform the treatment, or both, and the service, hospital or clinic in which it is proposed to perform the treatment; and
f) subsections (2) and (3) have been complied with.

Subsections (2) and (3) require the person to be given a written statement as to his or her legal rights including the right to withdraw consent at any time. As well, if necessary, an oral explanation and written statement must be given in a language with which he or she is familiar and is most likely to understand.

The constitution, membership and procedures of the Psychosurgery Review Board are spelled out in Schedule 3 of the Act.

Consent must be obtained from the board before psychosurgery can be undertaken (s 58(1)). Any medical practitioner who performs psychosurgery without first having obtained the consent of the Psychosurgery Review Board is guilty of professional misconduct and guilty of an offence under the Act (s 57(2)).

Application to undertake psychosurgery has to be made to the board setting out the details of the psychosurgery to be performed, the clinical indications for the psychosurgery, the hospital in which the surgery is to be performed, and that the patient is capable of giving informed consent or otherwise (s 58).

On receipt of the application to perform psychosurgery the Psychosurgery Review Board must convene within 10 days of receiving the application and must then hear the application within a further 21 days. Prior to hearing the application the board must give at least 10 days' notice to the following persons of their intention to hear the application:

- the applicant;
- the person on whom the surgery is to be performed;
- the advocate of the person on whom the surgery is to be performed;
- the primary carer.

The above persons are to be given all of the relevant details as to the time and place and nature of the proceedings as well as advising the person that they are entitled to legal representation before the hearing (s 59).

In hearing the application the Psychosurgery Review Board is required to act 'according to equity and good conscience' without regard to technicalities or legal forms. The board is not bound by the rules or practice as to evidence but may inform itself in relation to any matter as it thinks fit. Evidence may be given either

orally or in writing or partly orally and partly in writing by oath, affirmation or declaration (s 60).

In hearing the application the Psychosurgery Review Board is to be satisfied on the following matters found in section 65:

- the person in respect of whom the application is made has the capacity to give informed consent in accordance with the provisions of section 53B, earlier detailed in relation to ECT;
- the person in respect of whom the application is made has in fact given informed consent;
- the proposed psychosurgery has clinical merit and is appropriate;
- any person proposing to perform the psychosurgery is properly qualified;
- the service, hospital or clinic in which it is proposed to perform the psychosurgery is an appropriate place;
- all other reasonable treatments have already been adequately and skilfully administered without sufficient and lasting benefit;
- notice of the hearing has been given in accordance with section 59(2).

The board may either give consent to or refuse an application for psychosurgery (s 64). In giving consent to psychosurgery the board must specify the following matters as set out in section 66(1):

a) the name of the medical practitioner or medical practitioners authorised to perform the psychosurgery;
b) the nature of the psychosurgery to be performed;
c) the service, hospital or clinic in which the psychosurgery is to be performed;
d) the period within which the psychosurgery is to be performed.

Non-psychiatric treatment

On occasions, a person with a mental disorder may require surgery or treatment for a medical condition additional to the treatment being given for their mental disorder; for example, appendicectomy, repair of a hernia or treatment and medication for diabetes or heart failure. The Act makes provision for 'non-psychiatric treatment' defined in section 83 as follows:

a) any surgical operation or procedure or series of related surgical operations or procedures; or
b) the administration of an anaesthetic for the purpose of medical investigation; or
c) the administration of any course of treatment or course of medication requiring a prescription or medical supervision …

The Act refers to 'major non-psychiatric treatment' and 'not major non-psychiatric treatment'. What treatment falls into one of the two categories is not detailed in the Act but left to the Chief Psychiatrist to determine by the publication of written guidelines (s 83(1A)). In relation to non-major psychiatric treatment, the

patient may give consent voluntarily to treatment subject to being given a clear explanation of the proposed treatment and the reasons for it (s 83(2)).

In relation to non-psychiatric care generally, where the patient is incapable of giving informed consent to treatment and is over the age of 18 years, section 85(1) provides that consent to treatment may be given by:

- a person appointed by the patient under the *Medical Treatment Act 1988* (Vic); or
- a person appointed by the tribunal; or
- a person appointed under a guardianship order or enduring guardianship order; or
- an authorised psychiatrist.

Where the patient is under the age of 18 years, consent to treatment may be given by:

- a parent; or
- a guardian; or
- an authorised psychiatrist; or
- a person appointed under the *Children, Youth and Families Act 2005* (Vic).

Any person who performs non-psychiatric treatment on a patient without a proper consent being obtained in accordance with the Act is guilty of an offence against the Act. Further, any registered medical practitioner who performs such treatment without proper consent is also guilty of professional misconduct (s 84(2)).

Consent to undertake non-psychiatric treatment on a patient is not required if it is necessary to save the patient's life, prevent serious damage to the patient's health, or prevent the patient from suffering significant pain or distress (s 84(3)).

APPLICATION OF BODILY RESTRAINT AND SECLUSION

The Act makes specific reference to both of these forms of treatment. In the course of caring for patients where restraint and seclusion may be used, specific reference is made to the obligations imposed on registered nurses involved in such procedures.

Mechanical means of bodily restraint

Section 81 of the Act provides as follows:

> 1) Mechanical restraint of a person receiving treatment for a mental disorder in an approved mental health service can only be applied—
>
> a) if that restraint is necessary—
>
> i) for the purpose of the medical treatment of the person; *or*
>
> ii) to prevent the person from causing injury to himself or herself or any other person; *or*
>
> iii) to prevent the person from persistently destroying property; *and*

b) if the use and form of restraint has been —

i) approved by the authorised psychiatrist; *or*

ii) in the case of an emergency, authorised by the senior registered nurse on duty and notified to a registered medical practitioner without delay; *and*

c) for the period of time specified in the approval or authorisation under paragraph (b).

1A) In this section **mechanical restraint**, in relation to a person, means the application of devices (including belts, harnesses, manacles, sheets and straps) on the person's body to restrict his or her movement, but does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's capacity to get off the furniture.

1B) In the circumstances referred to in subsection (1)(b)(ii) the senior registered nurse must notify the authorised psychiatrist of the application of mechanical restraint as soon as practicable.

1C) It is not necessary to obtain a person's consent to the application of mechanical restraint to him or her.

1D) If mechanical restraint is applied to a person, he or she must —

a) be under continuous observation by a registered nurse or registered medical practitioner; *and*

b) be reviewed as clinically appropriate to his or her condition at intervals of not more than 15 minutes by a registered nurse; *and*

c) subject to subsection (1E), be examined at intervals of not more than 4 hours by a registered medical practitioner; *and*

d) be supplied with bedding and clothing which is appropriate in the circumstances; *and*

e) be provided with food and drink at the appropriate times; *and*

f) be provided with adequate toilet arrangements.

1E) The authorised psychiatrist may vary the interval at which a person to whom mechanical restraint is applied is medically examined under subsection (1D)(c), if the authorised psychiatrist thinks it appropriate to do so.

1F) If a registered medical practitioner or the senior registered nurse on duty or the authorised psychiatrist is satisfied, having regard to the criteria specified in subsection (1), that the continued application of mechanical restraint to a person is not necessary, he or she must without delay release the person from the restraint.

2) Any person who applies mechanical restraint to a person receiving treatment for a mental disorder in an approved mental health service in contravention of subsection (1) is guilty of an offence against this Act.

3) The authorised psychiatrist must at the end of each month prepare and send to the chief psychiatrist a report of the use of mechanical restraint specifying in each case —

a) the form of mechanical restraint used; *and*
b) the reasons why that restraint was used; *and*
c) the name of the person who approved or authorised the use of that restraint; *and*
d) the name of the person who applied that restraint; *and*
e) the period of time for which the person was kept restrained; *and*
f) if the authorised psychiatrist varied the interval at which the person was medically examined, the reason for that variation —

during that month. [italics added]

Seclusion

Section 82 defines 'seclusion' as follows:

1) In this section, **seclusion** means the sole confinement of a person at any hour of the day or night in a room of which the doors and windows are locked from the outside.
2) A person receiving treatment for a mental disorder in an approved mental health service may be kept in seclusion only —
   a) if it is necessary to protect the person or any other person from an immediate or imminent risk to his or her health or safety or to prevent the person from absconding; *and*
   b) if the use of seclusion has been —
      i) approved by the authorised psychiatrist; *or*
      ii) in the case of an emergency, authorised by the senior registered nurse on duty and notified to a registered medical practitioner without delay; *and*
   c) for the period of time specified in the approval or authorisation under paragraph (b).

2A) In the circumstances referred to in subsection (2)(b)(ii) the senior registered nurse must notify the authorised psychiatrist of the use of seclusion as soon as practicable.

2B) It is not necessary to obtain a person's consent to keep him or her in seclusion.

3) A person who is kept in seclusion must —
   a) be reviewed as clinically appropriate to his or her condition at intervals of not more than 15 minutes by a registered nurse; *and*
   b) subject to subsection (3A), be examined at intervals of not more than 4 hours by a registered medical practitioner; *and*
   c) be supplied with bedding and clothing which is appropriate in the circumstances; *and*
   d) be provided with food and drink at the appropriate times; *and*
   e) be provided with adequate toilet arrangements.

3A) The authorised psychiatrist may vary the interval at which a person who is kept in seclusion is medically examined under subsection (3)(b), if the authorised psychiatrist thinks it appropriate to do so.

3B) If a registered medical practitioner or the senior registered nurse on duty or the authorised psychiatrist is satisfied, having regard to the criteria specified in subsection (2), that the continued seclusion of a person is not necessary, he or she must without delay end the keeping of the person in seclusion.

4) Any person who keeps a person in seclusion in contravention of this section is guilty of an offence against this Act.

5) The authorised psychiatrist must at the end of each month prepare and send to the chief psychiatrist a report specifying in each case—
   a) the reasons why seclusion was used; *and*
   b) the name of the person who approved or authorised the use of seclusion; *and*
   c) the name of the person who kept the person in seclusion; *and*
   d) the period of time for which the person was kept in seclusion; *and*
   e) if the authorised psychiatrist varied the interval at which the person was medically examined, the reason for that variation—
   during that month. [italics added]

PATIENT RIGHTS, REVIEW OF CARE AND APPEAL MECHANISMS UNDER THE ACT

Patient rights

The Act seeks to protect the rights of persons who are brought within its provisions for the purposes of care, treatment and control. The objects of the Act in sections 4 and 5 are clearly directed to recognising the rights of people brought within the provisions of the Act and the need to ensure that their fundamental rights are protected. As an example, section 4(2) states:

> It is the intention of Parliament that the provisions of this Act are to be interpreted and that every function, power, authority, discretion, jurisdiction and duty conferred or imposed by this Act is to be exercised or performed so that—
>
> a) people with a mental disorder are given the best possible care and treatment appropriate to their needs in the least possible restrictive environment and least possible intrusive manner consistent with the effective giving of that care and treatment; *and*
>
> b) in providing for the care and treatment of people with a mental disorder and the protection of members of the public any restriction upon the liberty of patients and other people with a mental disorder and any interference with their rights, privacy, dignity and self-respect are kept to the minimum necessary in the circumstances. [emphasis added]

Having regard to the above provisions, it is clear that the intention of the Act is to ensure that persons who require care, treatment and control under the provisions of the mental health legislation in Victoria are not only given the best possible care but receive that care 'in the least restrictive environment' and that, to the maximum extent possible, patients retain the right to give and withhold consent to treatment. The Act also provides (s 5(b)) that one of the objectives of the Department of Health is:

b) to ensure that patients and other people with a mental disorder are informed of their legal rights and other entitlements under this Act and that the relevant provisions of this Act are explained to patients and other people with a mental disorder in the language, mode of communication or terms which they are most likely to understand.

Further reinforcement of a patient's rights under the Act can be found in section 18, which states as follows:

1) Every person on becoming a patient must be given the appropriate prescribed printed statement—
   a) advising the patient as to the legal rights and other entitlements of patients under this Act including the right to obtain legal representation and to have a second psychiatric opinion; and
   b) containing any other information relating to the treatment and care of the patient that the Department considers relevant including, in the case of a patient detained under section 20BJ(1) or 20MB of the Crimes Act 1914 of the Commonwealth, information as to his or her legal rights and other entitlements under that Act.
2) The statement may be printed in different languages so that wherever possible a patient can be given a copy of the statement printed in a language with which the patient is familiar.
3) In addition to the statement, the patient must be given an oral explanation of the information contained in the statement and, if he or she appears not to have understood, or to be incapable of understanding, the information contained in the statement, arrangements must be made to convey the information to the patient in the language, mode of communication or terms which he or she is most likely to understand.
4) It is the duty of the authorised psychiatrist to ensure that this section is complied with in the approved mental health service.

Appeal and review rights

Reference has already been made to the role of the Mental Health Review Board under the Act together with the Supreme Court and the Victorian Civil and Administrative Tribunal (VCAT). In summary, the respective roles of the three authorities are expressed below.

- The Mental Health Review Board has a statutory power to review decisions taken by an authorised psychiatrist concerning the detention and ongoing detention of an involuntary patient. That review mechanism is automatically provided for under the Act in that the board is required to review the detention of involuntary patients within the set statutory time limits. In addition, the Mental Health Review Board may hear an appeal from a patient detained under the Act at any time.
- Any decision or determination of the Mental Health Review Board may be reviewed by way of appeal process to VCAT. Further, the board may, of its own request or on the request of any person or party to proceedings before it,

make application to the Supreme Court of Victoria on a question of law which arises in any matter before it.

COMMUNITY VISITORS

In Victoria the role of reviewing mental health services on an ongoing basis is given to persons known as community visitors. These are people appointed by the governor on the recommendation of the minister of the day. The provisions applying in relation to the appointment of community visitors are set out in Schedule 5 of the Act.

The primary role of community visitors under the Act is to visit mental health services in Victoria for the purposes of inquiring into a number of aspects of those services. The term 'mental health service' is defined under section 107 as being that part (if any) of an approved mental health service *or* an agency providing community support services that provides residential services and 24-hour nursing care for people with a mental disorder.

In essence, all aspects of mental health services in Victoria are intended to be visited by a community visitor. Apart from the general statement that they are to visit mental health services in a particular area, the functions of a community visitor are spelled out in more detail in section 109 of the Act which states that community visitors are to visit and enquire into:

a) the adequacy of services for the assessment and treatment of people with a mental disorder; *and*
b) the appropriateness and standard of facilities for the accommodation, physical wellbeing and welfare of persons receiving treatment or care for a mental disorder; *and*
c) the adequacy of opportunities and facilities for the recreation, occupation, education, training and rehabilitation of persons receiving treatment or care for a mental disorder; *and*
d) the extent to which persons receiving treatment or care for a mental disorder are being given the best possible treatment or care appropriate to their needs in the least possible restrictive environment and least possible intrusive manner consistent with the effective giving of that treatment or care; *and*
e) any failure to comply with the provisions of this Act; *and*
f) any other matter that an official visitor considers appropriate having regard to the objectives specified in section 5; *and*
g) any complaint made to a community visitor by a person receiving treatment or care for a mental disorder. [emphasis added]

In undertaking their visits and inquiries, community visitors have very wide powers of inspection. Section 112 provides that a community visitor when visiting a mental health service is entitled to inspect any part of the premises to see any patient who is receiving treatment or care, unless the person receiving treatment for a mental disorder requests otherwise, and can make any inquiries relating to admission, detention, care, treatment and control of people in the particular service. In

addition, a community visitor may inspect any documents or medical records about a person's treatment or care as long as he or she has obtained the consent of the patient.

Further, any member of staff is required to assist the community visitor in carrying out their functions and, should any member of staff fail to do that or refuse or neglect to assist a community visitor, there are penalties provided under the Act (s 112).

Community visitors are represented by the Community (Psychiatric Services) Visitors Board and each year that board is required to submit a report to the Minister for Health about the activities of the community visitors; that report is also made available to Parliament.

Western Australia: *Mental Health Act 1996*

The long title of the Western Australian *Mental Health Act 1996* states that it is 'an Act to provide for the care, treatment, and protection of persons who have mental illnesses, and for related purposes'.

The objects of the Act as stated in section 5 are:

a) to ensure that persons having a mental illness receive the best care and treatment with the least restriction of their freedom and the least interference with their rights and dignity; and
b) to ensure the proper protection of patients as well as the public; and
c) to minimise the adverse effects of mental illness on family life.

DEFINITIONS

Section 3 contains the definition of particular words and terms used in the Act. However, the definition of 'mental illness' is in section 4 and states:

1) For the purposes of this Act a person has a mental illness if the person suffers from a disturbance of thought, mood, volition, perception, orientation or memory that impairs judgment or behaviour to a significant extent.
2) However a person does not have a mental illness by reason only of one or more of the following, that is, that the person —
   a) holds, or refuses to hold, a particular religious, philosophical, or political belief or opinion;
   b) is sexually promiscuous, or has a particular sexual preference;
   c) engages in immoral or indecent conduct;
   d) has an intellectual disability;
   e) takes drugs or alcohol;
   f) demonstrates anti-social behaviour.

Reference is also made throughout the Act to the term 'authorised hospital'. In section 21 provision is made for a public hospital to be authorised to admit people for the purposes of treatment under the Act.

In addition to the provisions of section 21, section 3 defines 'authorised hospital' as follows:

a) a public hospital, or part of a public hospital, that is for the time being authorised under section 21; and
b) a private hospital whose licence is endorsed under section 26DA of the *Hospitals and Health Services Act 1927*.

ADMISSION TO AND DETENTION IN AN AUTHORISED HOSPITAL

Voluntary admission and treatment

While the emphasis in the Act is directed towards the admission, detention, care and treatment of involuntary patients, there are circumstances where a person knows that he or she is mentally ill and voluntarily seeks admission to hospital for care and treatment. The term 'voluntary patient' is not defined in the Act. Nevertheless, by implication, the Act makes provision for such a patient when the provisions of sections 29 and 30 are considered. Section 29 confers a right on a medical practitioner or an authorised mental health practitioner who suspects a person should be made an involuntary patient to refer the person to a psychiatrist for examination. Section 30 provides that that right extends to a person 'who is a patient in an authorised hospital other than an involuntary patient …' and seeks to be discharged from hospital. In those circumstances, the person may be held for up to 6 hours for examination by a psychiatrist.

As well, section 107 requires that voluntary patients must give informed consent to electroconvulsive therapy.

Involuntary admission and treatment

In addition to the above, the provisions of section 26 of the Act would suggest that all patients admitted to an authorised hospital should be voluntary patients unless the provisions of that section apply. Section 26 provides:

1) A person should be an involuntary patient only if —
   a) the person has a mental illness requiring treatment;
   b) the treatment can be provided through detention in an authorised hospital or through a community treatment order and is required to be so provided in order —
      i) to protect the health or safety of that person or any other person;
      ii) to protect the person from self-inflicted harm of a kind described in subsection (2); or
      iii) to prevent the person doing serious damage to any property;

   and
   c) the person has refused or, due to the nature of the mental illness, is unable to consent to the treatment; and
   d) the treatment cannot be adequately provided in a way that would involve less restriction of the freedom of choice and movement of the person than would result from the person being an involuntary patient.
2) The kinds of self-inflicted harm from which a person may be protected by making the person an involuntary patient are —
   a) serious financial harm;

b) lasting or irreparable harm to any important personal relationship resulting from damage to the reputation of the person among those with whom the person has such relationships; and
c) serious damage to the reputation of the person.

In the first instance, section 29 provides that a medical practitioner or an authorised mental health practitioner may refer a person to a psychiatrist for examination if they suspect that person should be made an involuntary patient under the Act in accordance with the provisions of section 26.

A mental health practitioner includes a registered nurse as set out in section 19(1) as follows:

1) For the purposes of this Act a person is a mental health practitioner if he or she is —
   a) a psychologist; or
   b) a person —
      i) registered under the *Health Practitioner Regulation National Law (Western Australia)* in the nursing and midwifery profession; or
      ii) an occupational therapist registered under the *Occupational Therapists Act 2005*; or
   c) a person with another recognised qualification,
   d) and has at least 3 years' experience in the management of persons who have mental illnesses.

Section 20 states that the Chief Psychiatrist may designate a mental health practitioner as an authorised mental health practitioner if of the opinion the practitioner has qualifications, training and experience appropriate for the performance of the functions of an authorised mental health practitioner as set out in sections 29 and 63 of the Act.

The referral for examination is to be made to an authorised hospital and can only be made after the person has been examined by the medical practitioner or authorised mental health practitioner (s 31). If need be the 'referrer' may authorise the police to assist with transporting a person to an authorised hospital for examination (s 34). Once made, the authority to refer lapses after 48 hours (s 32).

The person referred for examination must be examined within 7 days (s 36(2)) and within 24 hours of arrival at the place where the examination is to take place.

After the examination if the psychiatrist believes the person should be an involuntary patient, the person is admitted to an authorised hospital or the psychiatrist may make a community treatment order (s 43). The psychiatrist may defer making a final decision as to the person's involuntary status for 72 hours and assess them again (s 37(1)(b) and (2)).

The initial period of detention in an authorised hospital must not exceed 28 days (s 48(2)) at which time the person must be examined again. A further period of detention of up to 6 months may be ordered or a community treatment order of up to 6 months may be made (s 49(4)). The person may be discharged from their

involuntary patient status at any time during the 6-month period if the psychiatrist considers it appropriate (s 52).

While in an authorised hospital, an involuntary patient may be given psychiatric treatment without the patient's consent (s 109).

EMERGENCY PSYCHIATRIC TREATMENT, SECLUSION AND RESTRAINT OF PATIENTS

Emergency psychiatric treatment

Provision is made in section 113 for a person to be treated in emergency circumstances if it is considered necessary:

a) to save the person's life; or
b) to prevent the person from behaving in a way that can be expected to result in serious physical harm to the person or any other person.

Psychosurgery is not permissible as an emergency psychiatric treatment (s 113(2)). Emergency psychiatric treatment may be given without consent (s 114). In giving such emergency treatment, section 115 provides that the following must be recorded:

- particulars of the treatment;
- the time and place at which, and the circumstances in which, the treatment was given; and
- the names of the person given treatment and the persons involved in giving the treatment.

A report regarding the giving of treatment, including the information that is required above, must also be sent to the Mental Health Review Board (s 115).

Seclusion

Section 116 defines 'seclusion' as 'sole confinement in a room that it is not within the control of the person confined to leave'. Seclusion can only be done in an authorised hospital (s 117) and must be authorised by a medical practitioner or, in an emergency, a senior mental health practitioner (s 118) in the following terms of section 119:

1) A person is not to give the authorisation to keep a patient in seclusion unless it is necessary for the protection, safety, or wellbeing of —
   a) the patient; or
   b) another person with whom the patient might come in contact if not kept in seclusion.

   Penalty: $1000.
2) Authorisation to keep a patient in seclusion is to be in writing and is to include particulars of the period for which the authorisation is given and anything else prescribed by the regulations.
3) A senior mental health practitioner who in an emergency authorises a patient to be kept in seclusion is to notify a medical practitioner as soon

as is practicable, and the medical practitioner may vary or revoke the authorisation.

Penalty: $1000.

4) Records of each authorisation to keep a patient in seclusion are required to be kept as prescribed by the regulations.

Pursuant to section 120, where a patient is kept in seclusion the treating psychiatrist is to ensure that:

a) appropriate provision is made for the basic needs of the patient, including bedding, clothing, food, drink and toilet facilities; and
b) the patient is observed by a mental health practitioner at regular intervals, as prescribed by the regulations; and
c) the patient is regularly monitored by a psychiatrist or another medical practitioner; and
d) a report of the patient being kept in seclusion is made as soon as is practicable to the Mental Health Review Board.

Restraint

Section 121 defines 'mechanical bodily restraint' in relation to a person as restraint 'preventing the free movement of the person's body or a limb by mechanical means, other than by the use of a medical or surgical appliance for the proper treatment of physical disease or injury'.

Like seclusion, restraint must be authorised by a medical practitioner, or, in an emergency, a senior mental health practitioner (s 122). Section 123 states that the circumstances in which restraint may be authorised is when it is necessary for:

a) the medical treatment of the patient; or
b) the protection, safety, or well-being of —
   i) the patient; or
   ii) another person with whom the patient might come in contact if the restraint is not used; or
c) preventing the patient from persistently destroying property.

The particulars of the authorisation are required to be in the following terms (s 123(2) and (3)):

2) Authorisation to use mechanical bodily restraint on a patient is to be in writing and is to include particulars of the period for which the authorisation is given and anything else prescribed by the regulations.
3) A senior mental health practitioner who, in an emergency, authorises the use of mechanical bodily restraint on a patient is to notify a medical practitioner as soon as is practicable, and the medical practitioner may vary or revoke the authorisation.

   Penalty: $1000.

Records of each authorisation to use mechanical bodily restraint on a patient are to be kept as prescribed by the regulations (s 123(4)).

FORMS AND TYPES OF TREATMENT UNDER THE ACT

Community treatment order

Section 68 of the Act outlines the terms of a community treatment order (CTO) that may be made as follows:

1) A community treatment order is to specify —
   a) a psychiatrist who will be responsible for supervising the carrying out of the order;
   b) a treatment plan outlining the treatment that the patient is to receive under the order and including details of —
      i) where and when the treatment is to be given; and
      ii) such other matters relating to the treatment as it is appropriate to specify; and
   c) a medical practitioner or mental health practitioner who will be responsible for ensuring that the treatment plan is carried out; and
   d) the time when the order will lapse, being not more than 3 months after the order comes into effect.
2) The order may include directions to the treating practitioner and to the psychiatrist who will be responsible for supervising the carrying out of the order as to reporting on the patient's progress.

A CTO must be confirmed within 72 hours, as provided in section 69, and may be revoked by the supervising psychiatrist in accordance with section 70.

Psychosurgery

Psychosurgery is defined and permitted within the provisions of sections 100 and 101 of the Act. Approval to conduct psychosurgery must be given by the Mental Health Review Board (s 102) in accordance with the provisions of section 103.

Electroconvulsive therapy (ECT)

ECT may be administered, subject to the conditions set out in sections 104 and 105 of the Act. Any disagreement by the relevant psychiatrist in withholding approval for ECT is to be determined by the Mental Health Review Board (s 106).

Treatment prohibited by the Act

Section 99 provides:

1) A person is not to administer to or perform on another person —
   a) deep sleep therapy; or
   b) insulin coma or sub-coma therapy.
2) A person who contravenes subsection (1) commits a crime.
   Penalty: Imprisonment for 5 years.

PATIENT RIGHTS, REVIEW OF CARE AND APPEAL MECHANISMS UNDER THE ACT

Official visitors

Section 177 makes provision for the appointment by the minister of persons as official visitors. Their primary role is to visit all authorised hospitals once a month (s 186) for the following purposes as identified in section 188:

a) to ensure that affected persons have been informed of their rights; and
b) to ensure that the rights of affected persons are observed; and
c) to inspect places where affected persons are detained, cared for, or treated under this Act and ensure that they are kept in a condition that is safe and otherwise suitable; and
d) to be accessible to hear complaints concerning affected persons made by those persons, their guardians or their relatives; and
e) to enquire into and seek to resolve complaints concerning affected persons made by those persons, their guardians or their relatives; and
f) if it would be appropriate for any other person or body to further enquire into or deal with any matter, to refer the matter to that person or body; and
g) to assist with the making and presentation of an application or appeal under this Act in respect of an affected person, or where authorised by this Act to do so, to make any such application.

In carrying out the above, official visitors may make such inquiries as they consider necessary and, where appropriate, inspect a patient's medical record (s 190(4)(c) and (d)).

MENTAL HEALTH REVIEW BOARD

Section 125 establishes the Mental Health Review Board. The board is required to regularly review the involuntary detention of patients.

The board is required to review an order made to detain a person as an involuntary patient as soon as practicable after the initial order is made but, in any event, not later than 8 weeks after the initial order was made (s 138). After that initial review, the board must conduct a periodic review every 6 months if the person continues to be an involuntary patient (s 139).

In addition to the above requirements, the board may carry out a review where the application is made by the patient concerned, an official visitor, or any other person who the board is satisfied has a genuine concern for the patient (s 142(2)) or where the board considers it appropriate to do so because of any report or complaint it receives (s 144).

Following any review undertaken, the board may make such order as it thinks fit and, in so doing, may:

- order that the person is no longer an involuntary patient;
- order that a community treatment order be made in respect of the person, giving such directions, if any, as it thinks fit in relation to the terms of the order; or
- if the person is the subject of a community treatment order, vary the order, and give such directions in relation to the order as it thinks fit (s 145).

Appeal and review rights

A person dissatisfied by a decision or order of the board may apply to the State Administrative Tribunal for review of the order or decision (s 148A). Any person dissatisfied with a decision or order of the State Administrative Tribunal may appeal to the Supreme Court on the grounds of an error of fact or law or both as well as jurisdiction (s 149). Other persons who satisfy the court they have a sufficient interest in the matter may appeal by leave of the court (s 149).

Endnotes

1) New South Wales Mental Health Drug and Alcohol Office, *The Mental Health Act (2007) Guide Book*, 4th ed, p 97 (lSBN 0 7313 2900 7).
2) Ibid, p 6.
3) Ibid, p 7.
4) Ibid, p 9.
5) Ibid, p 28.
6) Ibid, p 56.
7) Ibid, p 60.
8) Ibid, p 61.
9) Ibid, p 76.
10) Ibid, p 92.
11) Ibid, p 93.
12) Victoria Department of Health, *Review of the Mental Health Act 1986*, www.health.vic.gov.au/mentalhealth/mhactreview.

Index

Page numbers followed by 'f' indicate figures, 't' indicate tables, and 'b' indicate boxes.

A

B

C

D

E

F

G

H

I

J

K

L

M

N

O

P

Q

R

S

T

Z