Informed consent (adults and children)

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Related documents

C&C DHB policies:

- Resuscitation
- Human tissue – management and handling
- Blood/body substance and body fluid exposure
- Written information for patients / consumers
- Elder abuse
- Use of interpreter services
Policy

To ensure that proper processes relating to informed consent are followed so that all treatment provided to patients at C&C DHB and clinics is lawful.

Scope

All health professionals who provide health and disability services to patients for and/or at C&C DHB hospitals and clinics or in the community.

Introduction

Informed consent has its ethical basis in the principle of respect for autonomy. The Code of Health and Disability Services Consumers’ Rights 1996 (“Code of Rights”) is a key source of the law on consent in New Zealand, supplemented by other legislation and case law. The applicable rights in the Code of Rights are Rights 5, 6 and Right 7.

(a) Right 5 addresses a patient’s right to effective communication;
(b) Right 6 relates to a patient’s right to be fully informed; and
(c) Right 7 provides that treatment can only be provided to a patient if that patient makes an informed choice and gives informed consent, and sets out the competent patient’s right to accept or refuse any treatment.

The full text of the Code of Rights is reproduced in appendix 5.

The primary purpose of gaining informed consent is to empower patients and ensure that all treatment provided to patients is lawful. C&C DHB strives to ensure there is a continual and appropriate sharing of information throughout the patient’s treatment, accompanied by the provision of suitable advice to its patients. Sensitivity to cultural needs is required in all areas of informed consent.

Compliance with the Treaty of Waitangi

C&C DHB, as an agent of the Crown, recognises and accepts its obligations to the Treaty of Waitangi through the principles of partnership, participation, equity and protection. C&C DHB will meet its commitment to the Treaty by ensuring a bi-cultural partnership which will impact on all staff and the services it provides. Services must be provided in a manner that takes account of the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Maori (Right 1(3) Code of Rights). Health professionals should recognise that issues of culture, identity and whanau are relevant when issues of consent to health care of Maori patients arise. This will include informing the patient that whanau support is available if the patient so desires. Involvement of whanau may include participation in the decision-making, care and treatment of the patient, provided the patient has given consent for the whanau to be involved.

(Refer to C&C DHB Bicultural policies on SilentOne)

Definitions
Advance directive

In the Code of Rights an advance directive is defined as: “a written or oral directive:
(a) by which a consumer (patient) makes a choice about a possible future health
care procedure, and
(b) that it is intended to be effective only when he or she is not competent to provide
the necessary consent to accept or refuse medical treatment.”

Autonomy or right to self determination

This principle enables the patient to make decisions regarding medical treatments, no
matter how unwise others may consider them. Every competent adult has the right to
consent to or refuse treatment. It is acknowledged that individual autonomy is not
recognised in some ethnic groups, and this will need special consideration when dealing
with the voluntariness of any consent decision.

Child

For the purposes of the Care of Children Act a ‘child’ is a person under the age of 18.

Competence/capacity

A patient is considered competent to consent to, or refuse treatment, if he or she
understands the nature, purpose, effects and likely consequences of the proposed
treatment, or of refusing the treatment. The determination of a patient’s capacity to
consent is primarily assessed by clinical evaluation and judgement.

Diminished capacity

A patient’s competence or capacity to consent or refuse to consent to treatment may vary.
A patient may be competent to consent to one decision but not another, or to give consent
but not be competent to refuse consent.

Do Not Attempt Resuscitation (no-CPR)

“Do Not Attempt Resuscitation” (DNAR) means that in the event of a respiratory
arrest (patient is unresponsive and has stopped breathing) or circulatory arrest (patient
is unresponsive and pulse less), artificial means of maintaining and restoring ventilation
and circulation must not be applied. This will include artificial ventilation, cardiac
compression, defibrillation and the administration of resuscitation drugs. “DNAR” has
previously been known as “no-CPR”, “NFR” (Not For Resuscitation) and “DNR” (Do
Not Resuscitate).

DNAR does not apply to emergency interventions such as treatment of an obstructed
airway by manual airway control, or measures such as the Heimlich manoeuvre or
suctioning. Other interventions that may contribute towards prolongation of life such as
antibiotics and IV therapy are not part of the DNAR order, and must be considered
separately and documented accordingly in the patient’s management plan.

Emergency
An emergency is a situation where immediate action must be taken for the preservation of life or health (physical or mental) of the patient.

**Guardianship**

Under the Care of Children Act a guardian is a person who has all duties, powers, rights, and responsibilities that a parent of the child has in relation to the upbringing of the child. This includes determining for or with the child, or helping the child to determine questions about important matters affecting the child including non routine medical treatment. Guardianship terminates when the child reaches 18 years, the child marries, enters a civil union or when a child 16 years or older lives with another person as a de facto partner.

**Informed consent**

Informed consent is the process whereby someone (or another person legally entitled to consent on the first person’s behalf), who has the capacity/competence to consent to a given treatment, having been given sufficient information, voluntarily arrives at a reasoned decision as to whether or not to agree to the proposed treatment or procedure.

**Person legally entitled to consent on behalf of another person**

The only persons legally entitled to consent on behalf of another person are as follows:

Where a person is under 16 years:

(a) the child’s guardian(s) (who will usually be a parent);

(b) if there is no guardian in New Zealand or no guardian of that kind can be found with reasonable diligence or is capable of giving consent:

   – a person who has been acting in the place of a parent; or
   – a Court; or
   – the Chief Executive of the Child Youth and Family Service.

   *(section 36(3) Care of Children Act)*

(c) where a child has been lawfully placed for adoption in the home of a person that person. *(Under section 36(4) Care of Children Act that person is treated as a guardian of the child for the purposes of consent to treatment).*

Where the person is 16 years or over and incompetent to give consent:

(a) a welfare guardian appointed by the Family Court under the Protection of Personal and Property Rights Act;

(b) a person holding Enduring Power of Attorney (“EPA”), if the EPA entitles the person to consent to the particular treatment;

(c) any other person by order of a Court.

**Principle of necessity**
The principle of necessity is a common law justification for providing treatment without consent where there is a need to preserve the life, health and wellbeing of a person and the treatment is in the best interests of the person. The most common example of a situation where the principle of necessity allows treatment of a person without consent is an emergency situation.

**Treatment**

The term “treatment” is used throughout this policy to refer to health and disability services, treatment or procedures including the taking of images as the context requires.

**Consent process - key elements**

There are three key elements to informed consent. When obtaining a patient’s consent to treatment health professionals must ensure:

(a) that the patient is competent, or has the necessary capacity, to make the decision to undergo, or to refuse, treatment; and

(b) that the patient is provided with sufficient information to enable the patient to make an informed decision about the proposed treatment; and

(c) that the patient’s consent is given voluntarily.

Where one of these three elements is absent the individual cannot give a legally valid consent to medical treatment. Consent must be obtained for each treatment proposed, for example anaesthesia and surgery are separate treatments.

**Competency – capacity to consent**

**Determining competence**

For consent to treatment, or a refusal of treatment, to be legally valid, it must be made by a person with sufficient mental capacity or competence. Every patient must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the patient is not competent (Right 7(2) Code of Rights).

The determination of whether a patient is competent to consent to treatment is a matter for the clinical judgment of the health professional responsible for obtaining consent. In assessing competence we look at whether the patient can:

(a) understand the nature, purpose and effects of the proposed treatment;

(b) weigh up the options – pros and cons – balancing the risks and benefits;

(c) foresee the consequences of a decision or action;

(d) comprehend and retain the information; and

(e) communicate the decision.

**Level of competence required depends on type of treatment**

A person may be competent to consent to one decision but not another. For example, the
level of competence required to refuse life-sustaining treatment will be much higher than
the level of competence required to consent to routine treatment. When determining
competence, the issue is whether the individual has sufficient competence to consent to,
or refuse, the specific treatment in question. The question is whether that person’s
capacity to consent is so reduced that he or she does not sufficiently understand the
nature, purpose and effects of the proposed treatment

**Doubts about competence**

Should there be doubt about a patient’s competence, an opinion from a colleague
(supervising consultant for registrars) or consultant peer is prudent. In such cases, the
opinion should be recorded in the clinical file. Legal advice should be sought from C&C
DHB’s in-house legal advisor where there is still uncertainty.

**Provision of adequate information**

**Information that must be provided to the patient**

Under Right 6 of the Code of Rights, a patient has the right to receive information that a
reasonable patient in that patient’s circumstances would expect to receive. The
information should be communicated in a manner that will enable the patient to
understand the information.

In order for consent to be legally valid, a patient (or the person legally entitled to consent
on behalf of the patient) must have access to all the information that he or she requires to
make a fully informed decision about the proposed treatment. As a minimum the Code of
Rights requires, a patient to be given the following information:

(a) an explanation of his/her medical condition including the possible need for
   repeated minor procedures, e.g. intravenous or arterial access, naso-gastric tubes,
   for which one consent is acceptable for treatment of overall condition;

(b) an explanation of the options available including an assessment of the expected
   risks, side effects, benefits and cost of each option;

(c) advice of the estimated time within which the services will be provided;

(d) notification of any proposed participation in teaching or research, including
   whether the research requires and has received ethical approval;

(e) the results of tests and procedures;

(f) every patient (consumer) has the right to receive honest and accurate answers to
   questions relating to services, including questions about:
   
   – the identity and qualifications of the provider
   – the recommendation of the provider
   – how to obtain an opinion from another provider; and
   – the results of research

(g) a written summary of the information provided is requested.
Where a health professional believes the most suitable option for the patient is not available at C&C DHB, the health professional should inform the patient of the options available, including the health professionals preferred option. If this option is available privately, or may be available at C&C DHB some time in the future, the patient should be informed of this and provided with appropriate information to enable the patient to make an informed choice. Health professionals should have regard to potential conflict of interest issues when informing patients of options and providers.

**Disclosure of risks**

A patient has the right under Right 6(1)(b) to an assessment of the expected risks of each option. Risks that are far-fetched or fanciful need not be disclosed. However, a health professional must provide the patient with information that a reasonable patient, in the patient’s circumstances, would find material in making a decision about the proposed treatment and would be likely to attach significance to it.

To comply with this requirement, the health professional will need to consider the particular characteristics of the patient. A risk is “material” if a reasonable person would expect the particular patient to attach significance to it. What is material to one patient may not be material to another.

**Environment and manner**

The information should be given to the patient in a manner that enables the patient to understand the information and make an informed decision (Right 5). Where necessary, interpreters should be made available.

The environment should allow open, honest and effective communication. Every effort should be made to ensure privacy for discussions of diagnosis and treatment options. Where the patient wants it, it may also be appropriate to include a patient’s partner, family member or friend in the discussion. Sufficient time should be allowed for the patient to read written information and discuss this and any verbal information with whomever they wish.

**Voluntary choice**

Consent should be obtained in circumstances which do not place undue pressure on a patient. Health professionals should be sensitive to threats to the voluntariness of a patient’s decision, which may come from other sources, such as the patient’s close family members.

Notwithstanding the requirement of voluntary choice, the Code of Rights places a professional duty on health professionals to make recommendations as to the best course of treatment available. It is acceptable that the patient or his/her legal representative be persuaded in his or her choice by the arguments of health professionals and others, as long as the persuasion does not overbear the patient’s decision.
Obtaining consent – requirements

Responsibility for seeking consent

- The health professional who is performing the treatment has a duty of care to the patient to ensure the patient has given informed consent prior to treatment proceeding. This duty of care cannot be delegated.

- It is recognised that of necessity other members of the team may be involved in obtaining consent. However, the treating practitioner retains the legal responsibility for ensuring the patient has received the necessary information and advice to enable the patient to give informed consent.

- Where another practitioner obtains the patient’s consent, while the treating practitioner retains overall legal responsibility and accountability for the consent process, the second practitioner will be legally and ethically responsible for his or her own actions in obtaining the consent. He or she must be sufficiently familiar with the treatment to be able to answer the patient’s questions knowledgeably and provide the patient with information necessary for the patient to give legally effective consent to the treatment. The patient should be informed that this person will not be the person carrying out the treatment.

- The health professional performing the treatment and where the treatment is being performed under supervision, the health professional responsible for the treatment must ensure that the patient possesses a reasonable understanding of what is proposed, and has given informed consent to the treatment before the treatment is commenced.

- Anyone involved in the care or treatment of a patient, who believes the patient is not being adequately informed, should convey this to the person responsible. This should occur prior to the treatment or procedure being performed.

Timing of consent

- In many instances, it will be appropriate for a health professional to initiate treatment immediately after discussing it with the patient. For example, taking a routine blood test or performing a particular physiotherapy technique as part of an ongoing episode of care.

- Where the proposed treatment carries significant risks, or where written consent is required, the health professional must consider whether the patient has had sufficient chance to take in the information necessary for the patient to make an informed choice and give informed consent. Consent should be obtained a reasonable time prior to the treatment in order to allow for the patient to consider the information and make an informed choice.

- For consent to be legally valid the patient must not feel under undue pressure or that they must proceed with the treatment or cannot change their mind. In most circumstances consent should be sought before the patient has been prepared for the treatment (i.e. consent should not in normal circumstances be obtained after the patient is on the theatre trolley). Normally consent should be obtained before
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a premed or any medication which may impair the patient’s judgement is given. However the effect of medication is a matter of clinical judgement as some medication may improve the person’s capacity to consent. (e.g. analgesics for a patient in severe pain).

- In most cases where written consent is required, treatment options will be discussed with the patient well in advance of the actual treatment being carried out. The consent process may then involve two stages: the provision of information, discussion of options and an initial usually oral decision of the patient, followed by confirmation that the patient wishes to go ahead with the planned treatment. This second stage may occur at any appropriate time before the treatment, including in out-patients, at a preadmission clinic, or when the patient is admitted for treatment. What is important is that the patient has had time to take in and understand the information and options available, and does not feel under any undue pressure to consent.

- Care should be taken if for whatever reason consent has been obtained some time considerably before the treatment actually goes ahead. Whether consent obtained a considerable time before the treatment remains legally valid will depend on several factors including, the nature of the treatment and whether there has been a change in the patient’s condition or situation between obtaining consent and the treatment. If consent has been obtained considerably before the treatment actually goes ahead then the consent should be reviewed with the patient at an appropriate time prior to the treatment to ensure the consent remains valid.

**Consent recording - verbal and written**

In most situations verbal consent is sufficient, however health professionals are advised to obtain consent in writing whenever it is practicable to do so. The fact that verbal consent has been obtained should be recorded in the patient’s clinical record. It is also advisable to record the risks that have been discussed with the patient.

In certain situations written consent is required by law. C&C DHB also requires written consent in some situations which are in addition to those required by law.

**Under Right 7(6) of the Code of Rights written consent is required if:**

(a) the patient is to participate in any research; or  
(b) the procedure is experimental; or  
(c) the patient will be under general anaesthetic; or  
(d) there is significant risk of adverse effects on the consumer.

The Health and Disability Commissioner has stated that the requirement for written consent under Right 7(6)(d) includes where a prescription of medication will expose the particular patient to a **significant risk** of adverse effects.
C&C DHB also requires written consent in the following situations:

(a) where either party requests it;

(b) where a student is to undertake an examination or a treatment under the direct supervision of a registered health professional whilst the patient is under general anaesthetic or sedation, C&C DHB requires the patient’s written consent to the student performing the examination or treatment;

(c) where clinical video or photographic recordings (including digital photographs) are taken for educational or research purposes;

(d) where it is planned to retain any tissues, body parts or bodily substances that are removed or obtained in the course of a health care procedure;

(e) where transfusion of blood or blood products is required;

(f) where anaesthesia (regional or general) is required for treatment to be carried out. In this situation C&C DHB requires separate written consent for the anaesthesia.

The Mental Health (Compulsory Assessment and Treatment) Act requires that written consent be obtained:

(a) prior to treatment after the first month of compulsory treatment, with the exceptions noted in section 59; and

(b) prior to electro-convulsive treatment (section 60); and

(c) prior to brain surgery (section 61).

Written consent is also required under other statutes (refer to Appendix 1). Where there is any doubt advice should be sought from C&C DHB’s in-house legal advisor.

Consent documentation

Written consent should be documented on C&C DHB Informed Consent Form (see Appendices 5-6), as well as in the patient’s clinical record. As a guideline the following information should be documented:

(a) information given to the patient or the person legally entitled to consent on his or her behalf when this was done and by whom;

(b) the name and status of the person obtaining consent, and if different, the name and/or status of the person(s) who will carry out the treatment or procedure if this is known;

(c) specific queries made by the patient or his/her representative;

(d) any timeframe discussed with the patient;

(e) a statement of consent (whether given verbally or written);

(f) that the patient indicated that he or she understood the information given about
the proposed treatment.

**Incompetent adult patient**

(For situations involving children please refer to the section on Consent and Children)

**Diminished or varying competence**

Where a patient has diminished competence, the patient has the right to make informed choices and give informed consent to the extent appropriate to their level of understanding (Right 7(3)). The more serious the decision the greater the responsibility to ensure the patient does have the capacity to make an informed decision. The fact that a patient has diminished capacity to understand one explained treatment does not automatically mean that he or she is incompetent to consent to or refuse any other particular treatment.

The patient’s competence and capacity to consent should be assessed by senior medical staff and a clinical decision made about the ability of the patient to consent to the extent appropriate to that patient’s level of competence. A patient’s diminished capacity to consent may be due to either temporary or permanent factors. Permanent factors might include intellectual disability or severe mental illness. Temporary factors might include unconsciousness, confusion, shock, severe fatigue, pain, or use of prescription or illegal drugs.

What is important in determining competence to consent to, or refuse consent, is the specific treatment in question. The question is whether the patient’s capacity to consent is so reduced that he or she does not sufficiently understand the nature, purpose and effects of the proposed treatment.

**Treating patients without the capacity to consent**

The patient’s next of kin does not have any right to consent to or refuse medical treatment on the patient’s behalf unless they are a welfare guardian or hold an enduring power of attorney in respect of health care.

Where a patient is not competent to consent to a particular treatment that treatment may be able to be undertaken if:

(a) the patient has made a valid advance directive which applies in the situation; or

(b) consent is obtained from another person who is legally entitled to consent on behalf of the incompetent patient. For an adult patient this can only be the patient’s welfare guardian appointed by the Family Court under the Protection of Personal and Property Rights Act or a person holding enduring power of attorney for personal care and welfare appointed by the patient when the patient was competent under the Protection of Personal and Property Rights Act;

(c) it is in the best interests of the patient, and the responsible health professional has met the criteria in Right 7(4) (refer below); or

(d) authorisation is obtained from the courts.

Welfare guardians and personal care and welfare attorneys may not make decisions that are outside the scope of their powers as set out in the court order appointing the welfare
guardian or the deed appointing the attorney. In addition welfare guardians and attorneys cannot:

(a) refuse consent to any standard medical treatment or procedure intended to save a patient’s life or to prevent serious damage to a patient’s health; or

(b) consent to electro-convulsive treatment for a patient; or

(c) consent to surgery or any other treatment designed to destroy any part of the brain or brain function for the purpose of changing that person’s behaviour; or

(d) consent to a patient taking part in any medical experiment other than one for the purpose of saving that patient’s life or preventing serious damage to the patient’s health.

Where treatment is given in reliance on a welfare guardian’s consent a copy of the Family Court order appointing the welfare guardian should be placed on the patient’s records. Where treatment is given in reliance on the consent of a personal care and welfare attorney a copy of the deed appointing the attorney should be placed on the patient’s records. Where the treatment is a major medical procedure a “Health Practitioner’s Certificate of Mental Incapacity for Enduring Power of Attorney in relation to Personal Care and Welfare” Form should be completed and a copy placed on the patient’s records.

In the absence of a person who is entitled to consent on behalf of the patient, Right 7(4) of the Code of Rights allows a health professional to administer treatment to an incompetent patient provided the following criteria are met:

(a) it is in the best interests of the patient; and

(b) reasonable steps have been taken to ascertain the views of the patient; and

(c) either:

   (i) if the patient’s views have been ascertained, and having regard to those views, the health professional believes, on reasonable grounds, that the provision of services is consistent with the informed choice the patient would make if he or she were competent; or

   (ii) if the patient’s views have not been ascertained, the health professional takes into account the views of other suitable persons who are interested in the welfare of the patient and available to advise the health professional.”

This would include such people as the patient’s permanent care givers, his or her GP, next of kin and whanau.

Once the health professional has taken into account the views of other people interested in the welfare of the patient, he or she alone has the final decision as to whether or not to provide the proposed treatment to the patient. In some circumstances it may be appropriate to seek a second opinion.

If treatment is provided in reliance on Right 7(4) of the Code of Rights, it is important
that the health professional maintains accurate written records to demonstrate that they have fulfilled their obligations under the Code. Where treatment is given to an incompetent adult in reliance on Right 7(4) the standard consent form should not be signed by the health professional or the patient’s relatives. Instead where written consent is required the “Form for Treatment Without Consent (where there is no person legally authorised to give consent)” should be used.

Where treatment is very urgent and it is not feasible to fill in the above form at the time, the form should be used to document the clinical decision and treatment afterwards. For treatment in an emergency situation refer to the section “Consent in an emergency” below.

Where a patient is not competent to make a particular decision, health professionals should endeavour to provide information in a way the patient can understand, and where possible gain their acceptance of the treatment. The extent to which this can be achieved will vary from patient to patient, but as a general principle decisions about the management of patients who are not competent will involve the patient as much as possible.

**Consent in an emergency**

In an emergency the primary need is to treat the patient. However, even in an emergency a patient who is competent to consent has the right to consent to or refuse medical treatment. The proposed treatment, the benefits and risks associated with consenting and refusing to consent to the treatment, and other options must be fully explained to the patient but the decision remains that of the patient.

Where a patient does not have the capacity to consent (or refuse consent) the principle of necessity allows treatment to be given to a patient where such treatment is necessary and would be taken by a reasonable person in the circumstances to preserve the life or health of the patient.

Only treatment that is necessary for the patient’s immediate well-being and which is in the best interests of the patient can be carried out. The treatment must be, and be no more than, what a reasonable patient would expect to receive in all the circumstances.

Treatment that goes further than securing the immediate needs of the patient cannot be carried out without the patient’s consent unless:

(a) a specific order has been made by the Family or High Court;

(b) consent has been given by a person legally entitled to consent on behalf of the patient, ie:

- For adults this may be a welfare guardian appointed by the Family Court; or an attorney appointed under a deed of enduring power of attorney in relation to personal care and welfare.

- For children under 18 years this may be the child’s guardian or a person entitled to consent under section 36(3) Care of Children Act. Special care must be taken in the case of young persons and older children who have the capacity to consent if the
child’s and/or the guardian’s wishes differ from the recommendation of the child’s health professional. Refer to the section on “Consent and children.”

Medical intervention cannot be justified on the basis of the principle of necessity, even in an emergency situation, where it is contrary to the known wishes of the patient, e.g. where there is an advance directive given by the patient when competent to give such a directive (Right 7(7) and section 11 New Zealand Bill of Rights Act).

In the situation where a child requires emergency treatment and the parent/guardian cannot be found, or there is no time to attempt to obtain the consent of the child’s guardian(s), treatment necessary to preserve the life or health of the child and which is in the best interests of the child can be provided.

Where the child is competent but under 18 years of age and is refusing emergency treatment required to prevent a serious risk to the child’s life or health, or where a child’s guardian is refusing treatment for the child in an emergency situation special care must be taken. Legal advice should be sought from C&C DHB’s in-house legal advisor.

The responsible health professional should document the actions taken, including the reason for consent not being obtained where treatment is given without consent.

After the emergency has passed, the patient, or person legally entitled to consent on behalf of the patient must be told of the treatment provided.

**Right to refuse medical treatment**

**The competent patient**

A competent adult patient who has the capacity to consent, may refuse to consent to medical treatment even if it results in that patient’s injury or death, including in an emergency situation. A health professional has no right to proceed in the face of a competent patient’s refusal.

The right to refuse treatment is based on the following:

(a) the common law right to self determination;

(b) section 11 of the New Zealand Bill of Rights Act;

(c) Right 7(7) of the Code of Rights.

A health professional may have further discussion with the patient who is refusing the treatment in an effort to change his/her mind. However, the right to refuse treatment is not limited to decisions that are sensible; it exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent.

There is no requirement that a patient’s refusal to consent to medical treatment be in writing in order to be valid. Health professionals should, however, endeavour to obtain such a refusal in writing. Full documentation in the patient’s clinical record should be
completed by the responsible health professional, outlining the exchanges between the health professional and the patient.

**When a competent patient refuses to consent to life-sustaining treatment**

When faced with a competent patient’s refusal to consent to life-sustaining treatment:

(a) The responsible health professional should immediately consider whether there is any reason to doubt the patient’s competence to consent to or refuse the treatment.

(b) If the competence of the patient is seriously in doubt, it should be assessed as a matter of priority. In most cases, the responsible doctor will be able to assess competency. In some cases, it may be appropriate for a psychiatrist to assess the patient and this should be considered and discussed where the circumstances suggest it is appropriate. If there remains any doubt, legal advice should be sought from C&C DHB's in-house legal advisor.

(c) If the patient is competent and refuses to consent to the treatment, the advice given to the patient should be recorded.

(d) The patient should be asked to confirm in writing that he or she understands the nature of, and the reasons for, the proposed treatment, and the risks and likely prognosis involved in the decision to refuse or accept the treatment.

(e) If the patient is unwilling to sign a written indication of the refusal, the health professional should document the patient's refusal in the patient's clinical record.

**Patient with diminished or varying competence**

In the event that a patient with diminished or varying capacity to consent refuses treatment, or a welfare guardian, or person with an enduring power of attorney in relation to personal care and welfare refuses to consent, the right to refuse treatment must be considered carefully. Difficulty may arise when considering whether or not a patient understands the consequences of refusing consent.

Legal advice should be sought from C&C DHB's in-house legal advisor if there is any uncertainty as to the patient's capacity to refuse treatment the health professional considers to be in the patient's interests.

In the case of a welfare guardian, or person with an enduring power of attorney refusing consent, the welfare guardian or attorney must act in the best interests of the patient. Welfare guardians and attorneys may not refuse consent to any standard medical treatment or procedure intended to save a patient’s life or to prevent serious damage to a patient’s health.

**Advance Directives**

Right 7(5) of the Code of Rights allows every patient to use an advance directive in accordance with common law. An advance directive is made when a competent person sets out in advance the circumstances when they would consent, or refuse consent to
certain treatment in the event that the person is not competent to give or refuse consent at the time.

An advance directive must contain a clear statement by the patient as to his or her choice to consent to, or refuse, a future treatment. An advance directive should be carefully scrutinised to ensure it is valid in the patient's current circumstances. The following five issues need to be considered when determining whether a directive is valid:

(a) whether the patient was competent to make the particular decision when the decision was made;

(b) whether the patient made the decision free from undue influence;

(c) whether the patient was sufficiently informed to make the decision;

(d) whether the patient intended his or her directive or choice to apply in the circumstances; and

(e) when it was written (how long ago).

An advance directive may require that some condition be met before the choice in the advance directive is activated. If the advance directive includes a pre-condition upon which the directive is based, and this condition does not exist, and the patient is unconscious, or otherwise incompetent, then he or she should be treated by the health professional as if they had not made a decision with respect to the medical treatment proposed.

An advance directive cannot be ignored unless there are reasonable grounds to doubt one of the four factors listed above. However a health professional would be justified in fully scrutinising the validity of an advance directive, if it involved the refusal of treatment necessary to save the patient’s life or prevent serious damage to the patient's health.

Where the patient has made an advance directive and the patient is unconscious, or otherwise incompetent and has a personal care and welfare attorney or a Court appointed welfare guardian then the attorney or welfare guardian may (but is not bound to) follow the patient’s valid advance directive. Where there is a clear conflict between the patient’s wishes as indicated in the advance directive and the health professional’s recommendations then the attorney or welfare guardian may seek direction from the Family Court.

The exception to the powers of welfare guardians and attorneys regarding advance directives is that the attorney or welfare guardian cannot refuse consent to any standard medical treatment or procedure intended to save the patient’s life or to prevent serious damage to the patient’s health regardless of any advance directive on such treatment (s18(c) and s99A(2) of the Protection of Personal and Property Rights Act). The legal prohibition against refusing consent on such treatment or procedure applies even if the patient has stated in the EPA (if dealing with an attorney) that the attorney may act in that way (and nor can the Court include such a power to act under an EPA or order appointing a welfare guardian).

The effect of the legal restriction on the powers of attorneys and welfare guardians regarding standard life saving treatment and standard treatment to prevent serious damage to health is that the health professional cannot act on a refusal of consent to such
treatment from the welfare guardian or attorney but should act in accordance with the advance directive as described above, i.e. an advance directive cannot be ignored unless there are reasonable grounds to doubt one of the five factors listed above. However a health professional would be justified in fully scrutinising the validity of an advance directive involving the refusal of such treatment.

Where there is conflict between the recommendations of the health professional, the patient’s advance directive and/or the views of the welfare guardian or personal care and welfare attorney then legal advice should be sought from C&C DHB's in-house legal advisor, particularly if there is uncertainty as to what constitutes ‘standard treatment’ if there is risk to the patient’s life or health.

**Do Not Attempt Resuscitation orders (DNAR orders)**

In certain circumstances set out in C&C DHB’s Resuscitation Policy a DNAR order may be initiated. A DNAR order must be recorded in writing and be attached to the patient’s clinical record. Refer to C&C DHB's Resuscitation Policy for further information.
Specific clinical situations

Patient with a mental or intellectual disorder

Mental and intellectual disorders do not in themselves necessarily preclude a patient having the capacity to consent to treatment. The Code of Rights continues to apply to patients with a mental or intellectual disorder, including patients subject to compulsory treatment under the Mental Health (Compulsory Assessment and Treatment) Act, Criminal Procedure (Mentally Impaired Persons) Act or Intellectual Disability (Compulsory Care and Rehabilitation) Act (date).

The above Acts provide for limited situations where certain treatment may be provided without the patient’s consent. It is still necessary to attempt to obtain consent. Treatment authorised under the relevant Act as being able to be given without the patient’s consent may be given without consent. As long as the treatment is given in accordance with the relevant Act this will not breach the Code of Rights. Relevant mental health policies and guidelines, and any guidelines promulgated by the Director-General under section 148 Intellectual Disability (Compulsory Care and Rehabilitation) Act must be followed.

A person subject to compulsory treatment under the Mental Health (Compulsory Assessment and Treatment) Act (date) may be given treatment for mental disorder without consent. Treatment for ‘mental disorder’ has been defined broadly however it does not cover treatment for other clinical conditions. Where treatment for other clinical conditions is in the person’s best interests and the person is not competent to give informed consent then consent will need to be given by a person legally entitled to give consent, or treatment may be given in reliance on Right 7(4) of the Code of Health and Disability Services Consumers’ Rights. Where Right 7(4) of the Code cannot be relied upon in the circumstances then orders for treatment will need to be sought from the Family Court under the Protection of Personal and Property Rights Act.

If there is any doubt the matter should be discussed with the Director of Area Mental Health Services where appropriate. Where necessary legal advice should be sought from C&C DHB’s in-house legal advisor.

Accidental blood or body fluid exposure

Where a staff member has been exposed to another person's blood or body fluid, refer to the Blood/Body Substance and Body Fluid Exposure Policy.

Pathology confirmed during surgery/additional procedures

When potential pathology may be confirmed during surgery or any other procedure, whilst the patient is under anaesthetic or otherwise unable to consent for any reason, the possibility of appropriate further surgery/treatment must be discussed with the patient as part of obtaining consent for the original surgery/procedure. The patient should be informed of the possible nature of the additional surgery/procedure, risks, alternative options and the consequences of non-consent, e.g. further surgery. Information given to the patient and the patient’s consent or refusal to consent to additional procedures must be documented on the consent form or in the patient’s clinical record.

If the patient is unable to make an informed decision without a confirmed diagnosis, consent to an additional procedure occurring at the same time as the first procedure...
should not be sought and the second procedure should not be performed until informed consent is received, unless it is necessary to perform the procedure immediately in order to preserve the patient’s life or health.

Other treatment that the patient has not given consent for, and therefore is not listed on the consent form or in the patient's clinical record, should not be performed unless they meet the requirements of "Consent in an Emergency”.

**Photography, video and audio recording**

Clinical photographic, video and audio recordings of patients may be made as part of patient diagnosis and management or for education and/or research. Such imaging falls within the definition of treatment in the consent form. Where the recording is made for the purposes of education or research refer to Appendix 3 of this policy.

Where recordings are made as part of the patient’s treatment process, the recordings must not be used for any other purpose including education and research without the patient’s consent. Special requirements apply for patients with a mental disorder who come under the Mental Health (Compulsory Assessment and Treatment) (CAT) Act.

**Tissue, body parts and bodily substances**

Right 7(9) of the Code of Rights gives every patient the right to make a decision about the return or disposal of any body parts or bodily substances removed or obtained in the course of a health care procedure. To give effect to this right, where tissue, body parts, or bodily substances (excluding blood or other bodily fluids) is to be removed or obtained in the course of treatment, information must be provided to the patient to enable the patient to make an informed choice and give informed consent to the use and/or disposal of the tissue, body part, or bodily substance.

Under Right 7(10) no body part or bodily substance removed or obtained in the course of a health care procedure may be stored, preserved or used without the informed consent of the patient or a person legally entitled to consent on behalf of the patient.

The only exception to this is where the body part or bodily substance is to be used for:

(a) research that has been approved by an ethics committee; or

(b) the purposes of a professional quality assurance programme, external audit of services or an external evaluation of services (Right 7(10)(b) and (c)).

The patient, or a person legally entitled to consent on behalf of the patient in the case of a child or incompetent adult should be offered the opportunity:

(a) to reclaim the patient's tissue, body part or bodily substance as is the custom at present; or

(b) to give their informed consent for the tissue, body part or bodily substance to be stored or preserved and used for further diagnostic purposes. C&C DHB requires the patient's consent to be in writing.

For further information refer to C&C DHB's “Human Tissue – Management and Handling Policy.”
Consent and children

The legal position in New Zealand concerning consent and refusal of treatment by young persons under 18 years is complex and different from the position for persons over 18 years. In New Zealand, the Care of Children Act and Code of Rights are important sources of the law on consent for children.

Under the Code of Rights there is no “age of consent,” and all patients are to be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the patient is not competent (Right 7(2)). Whether a child will be competent to consent to a particular treatment will depend on the nature of the treatment, the risks involved and the maturity of the child. Extreme youth is an obvious ground for believing the child is not competent. The Code of Rights co-exists with other laws and health professionals’ ethical obligations.

Under the Care of Children Act a child is defined as a person under the age of 18 years. At the same time the Act provides that the consent of a child 16 years or over is to be treated as if the consent was given by an adult (section 36). The Act is silent as to whether or not a child under 16 years can give legally valid consent or can refuse consent. However, the Act specifically provides for persons who may consent or refuse consent on behalf of a child when the consent of another person is “sufficient or necessary” (section 36(3) and (4)).

It is important to remember that regardless of the child’s age, their consent will only be legally valid if the child is competent to give consent for the particular treatment in question.

If a child requires emergency treatment please refer to the section “Consent in an emergency.”

Competent child

Under section 36 Care of Children Act a competent child who is 16 years or over, or who is or has been married, living in a civil union or defacto relationship (as defined under the Act), can consent, and refuse consent, to any medical, surgical or dental procedure (including blood transfusion) as if the child were of full age.

A health professional may presume that a child of 16 years or over has the capacity to consent, and refuse to consent to treatment unless there are reasons other than age to doubt competency. However, while a competent child of 16 or 17 years of age has the right to consent and refuse consent to treatment, where a competent child aged 16 or 17 years is refusing lifesaving treatment against the recommendation of a health professional, legal advice should be sought.

Section 36 of the Care of Children Act does not specifically exclude children under 16 years consenting or refusing consent to treatment. However, under section 38 a competent girl of any age may consent to, or refuse consent to, a termination of pregnancy as if she were an adult (section 38).

Apart from consent relating to termination of pregnancy it is therefore not clear from reference to the Act alone whether a guardian’s consent is always necessary for medical treatment or procedures for children under 16 years. Section 36(3)(a) of the Care of
Children Act gives a guardian the right to consent or refuse consent to treatment in respect of a child under his or her guardianship where the consent of another person is “necessary or sufficient.” In addition, the presumption of competence contained in Right 7(2) of the Code of Rights allows children under the age of 16 years to consent (and refuse consent) to treatment, if they are competent to make a decision about the particular treatment.

Ultimately an assessment of whether a particular child is competent to consent (or refuse consent) to proposed treatment will depend on the understanding and maturity of the child, and the gravity of the treatment. Obviously age is a relevant factor to be considered when determining a child’s competence to make a particular decision, but the Code of Rights recognises that the age of the patient is only one of a number of factors to be taken into account.

**Persons legally entitled to consent on behalf of a child**

Under section 36(3) Care of Children Act where the consent of another person is “necessary or sufficient” consent may be given by:

(a) a guardian of the child; or

(b) where there is no guardian in New Zealand (or that can reasonably be found or who is capable of giving consent), a person acting in the place of a parent to consent; or

(c) if there is no person acting in place of a parent, or no such person can reasonably be found or is capable of consenting, consent can be given by a District Court Judge or the chief executive of the Department of Social Welfare.

The Act also provides that where a child has been lawfully placed for adoption in the home of a person, that person is to be treated as a guardian of the child for the purposes of consent to treatment (section 36(4)) (Refer to sections on ‘Guardianship’ and ‘Child subject to an order under the Children, Young Persons and Their Families Act’ below).

Section 36(3)(b) of the Care of Children Act (above) provides for “a person in New Zealand who has been acting in the place of a parent” to give informed consent for the child in their care (where the consent of someone other than the child is necessary). This is an important practical provision as in many cases a child’s actual carer is not a parent but the carer otherwise does not have any legal status in respect of the child (i.e. is not a legal guardian of the child). Where the child is not competent to give consent and is cared for by someone other than a parent who does not have any legal status as regards the child it will be important to ascertain if a parent(s) can be located and to take reasonable steps in the circumstances to contact the parent before obtaining consent from the carer. If the parent cannot be located or is not capable of giving consent then the carer is legally entitled to give informed consent for the child, provided of course that the carer is competent to do so. In situations where it may be difficult to determine who, if anyone, may give consent legal advice should be sought from C&C DHB’s in-house legal advisor.

Where a competent child under 16 years of age refuses treatment against the wishes of his or her guardian or the advice of the health professional concerned, or where there is any dissent between the parent/guardian and the child, or between guardians, legal advice should be sought from C&C DHB’s in-house legal advisor.
Incompetent child

Children of any age who are not competent to consent to a particular treatment are not able to consent to that treatment. The child however, retains the right under the Code of Rights to be fully informed, to make informed choices and give informed consent to the extent appropriate to his or her level of competence. Where appropriate the proposed treatment should be explained to the child prior to the treatment going ahead.

In the absence of a person who is entitled to consent on behalf of an incompetent child, (refer above) a health professional may still be able to provide treatment provided the criteria in Right 7(4) Code of Rights are met.

16 and 17 year olds

The Care of Children Act gives competent 16 and 17 year olds the right to consent and refuse to consent to treatment for themselves (section 36).

However, the law is unclear as to whether a guardian (or a substitute specified in section 36(3)(b) and (c) of the Act - refer to section “Persons legally entitled to consent on behalf of a child” above) can give legally effective consent or refusal to consent to treatment for a 16 or 17 year old against a competent 16 or 17 year old’s wishes. The law is also unclear as to whether a guardian (or other person with legal authority) can give legally effective consent or refusal to consent to for a 16 or 17 year old who is incompetent and therefore incapable of consenting or refusing consent to treatment.

This uncertainty comes about because a person of 16 and 17 years is still a child under the Care of Children Act, and therefore the child’s guardians in general retain guardianship rights and responsibilities in relation to the child. Therefore, it is unclear whether a guardian’s right to consent and refuse consent on behalf of the child expires when the child reaches 16 years, (or even when a child under 16 years is competent, based on the presumption of competence in the Code of Rights), or whether the guardian’s right continues to co-exist with the competent child’s right to consent to treatment for themselves until the child reaches 18 years of age.

In difficult situations where there is conflict between what the health professional believes is in the child’s best interests and what the child and/or his or her guardian believes to be in the child’s best interests, legal advice should be sought from C&C DHB’s in-house legal advisor.

Refusal to consent to treatment

Under the Care of Children Act a competent child 16 years or over can refuse to consent to any donation of blood or to any medical, surgical, or dental treatment or procedure, as can a child who is or has been married or living in a de facto relationship.

Careful consideration must be given to whether the child is competent to make the particular decision. If a child refuses treatment, it usually indicates that s/he is afraid. The child may also be too ill to think clearly. The most powerful way to reduce a child’s fear will be to give a clear explanation of what is involved, at a level the child understands.

The Care of Children Act is silent on whether a competent child under 16 years can refuse to consent to medical treatment. This situation places health professionals in a difficult
position especially where the treatment is considered necessary to save the child’s life. Failure to provide treatment in this circumstance may expose the health professional to legal liability and special care must be taken. In addition, New Zealand law imposes on parents/guardians a legal duty to supply a child in the parent/guardian’s actual custody with the “necessaries” of life. This includes medical treatment. A child’s refusal to consent to life-saving treatment where the child was under 16 years of age has been treated by a New Zealand court as not providing the child’s parents/guardians with a lawful excuse for not obtaining medical treatment in accordance with this legal duty.

This area of the law is uncertain, and if there is any doubt, particularly where the consequences of the refusal may be serious, health professionals should proceed with caution and seek legal advice from C&C DHB’s in-house legal advisor.

An incompetent child cannot refuse to consent to medical treatment. The child retains the right to make informed choices and give informed consent to the level appropriate to his or her level of competence. Where a child is incompetent to refuse consent the child’s guardians may refuse to consent to medical treatment for the child in certain circumstances. However, this right is limited by the requirement that parental decision making must be in the best interests of the child and a legal duty to supply a child in the parent/guardian’s actual custody with the “necessaries” of life. This includes medical treatment. Parental rights are derived from parental duty, and exist for the benefit of the child.

Where conflict about treatment occurs the health professional should first identify a mediator who is acceptable to the child and the parents/guardian, to facilitate a resolution. Mediators may include other family members, chaplains, kaiawhina, child psychologists, social workers, etc. Helpful guidance may be obtained from the discussion document prepared for the Paediatric Society of New Zealand and the Board of Paediatrics and Child Health of the Royal Australasian College of Physicians, titled 'Disagreements between Professionals and Families about Health-Care for Children', August 2001.

Legal advice should be sought if the health professional believes treatment is required to prevent a serious risk of harm or prolonged pain or suffering to the child and:

(a) the health professional and parents/guardians disagree as to the course of treatment to be administered to the child; or

(b) the parents/guardians disagree between themselves; or

(c) a child under 16 years who is assessed as being competent to consent to treatment makes a decision about treatment that is incompatible with his or her parent’s/guardians decision and/or the recommendation of their health professional.

If parents/guardians refuse consent and the health professional believes that this is against the best interests of the child, it may be necessary to seek a Court Order to enable the child to receive treatment. This process can be fraught with difficulty and must be managed with extreme sensitivity and care. Legal advice should be sought from C&C DHB’s in-house legal advisor.

**Termination of pregnancy**
Section 38 of the Care of Children Act provides that where a girl of any age consents to, or refuses consent to, a termination of pregnancy the child is treated as an adult for the purpose of consent.

**Child subject to an order under the Children, Young Persons and Their Families Act**

The Family Court may make a number of orders relating to the custody or guardianship of a child or young person which change who is entitled to consent on behalf of a child or young person. These orders include a custody order, an interim custody order, or a guardianship order.

If any of these orders have been made, the responsible health professional must establish immediately who is authorised to consent to treatment on behalf of the child or young person. The parents of the child, or any other person expressing an interest in the welfare of the child, may not have any rights in respect of the care of the child and the manner in which the child is treated.

Consent for non routine medical treatment is an aspect of guardianship, not custody. A health professional must always check whether a person or service granted a custody order, also has a guardianship order, or whether anyone else retains guardianship rights. Where there is any doubt as to who can consent to treatment, legal advice should be sought from C&C DHB’s in-house legal advisor.

**Guardianship**

It is the fact of guardianship that entitles a parent to consent on his or her child’s behalf. Generally, a child’s parents will be the child’s legal guardians. The child’s mother will always be a guardian (unless her guardianship has been removed by the Court). Under the Care of Children Act if the father was married to or living in a de facto relationship with the mother at any time during the period beginning with the conception of the child and ending with the birth of the child he will share automatic guardianship of the child with the mother.

A parent who is not a legal guardian is not legally entitled to consent on behalf of the child. If there is any doubt about the parents’ guardianship, legal advice should be sought.

A guardian has duties, powers, rights and responsibilities relating to the upbringing of the child, including determining for or with the child, or helping the child to determine, questions about important matters (such as name, living arrangements, non-routine medical treatment, education, culture and religion). A guardian continues to have the duties, powers, rights, and responsibilities of a guardian in relation to the child, whether or not the child lives with the guardian, unless a Court order provides otherwise.

Guardianship ends when:

(a) the child turns 18, unless the child marries before that age or enters into a de facto relationship (section 28 Care of Children Act); or

(b) a guardianship order expires; or
(c) a guardian is removed by an order of the Court (sections 28 and 29 Care of Children Act).

A health practitioner is entitled to act on the consent of any one guardian, however where guardians disagree as to whether to consent to or refuse consent to treatment, or there is uncertainty over who has legal capacity to give consent legal advice should be sought from C&C DHB’s in-house legal advisor.

**Provision of information**

Under Right 6 of the Code of Rights a “consumer” has the right to receive information that a reasonable consumer in that consumer’s circumstances would expect to receive, communicated in an effective way. “Consumer” is defined to include a person entitled to give consent on behalf of that consumer for the purposes of provision of information and consent.

Therefore, both the child and the child’s guardian(s), where the guardian is legally entitled to give consent, should normally be provided with the information necessary to give informed consent to treatment, including the information set out in Right 6. Where a competent child does not wish his or her guardians/parents to be informed, the health professional should respect this wish and seek legal advice from C&C DHB’s in-house legal advisor.

A child should be provided with information about the treatment that is suitable to the child’s age, maturity and interest, and this information should be communicated in a form, language and manner that enables the child or young person to understand to their level of competence (Right 6 of the Code of Rights and the UN Convention on the Rights of the Child).

**References**

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*Coles Medical Practice in NZ 2008:* Ian St George, Editor, Medical Council of New Zealand

*Consent in Child and Youth Health:* Ministry of Health 1999

*Disagreements between Professionals and Families about Health-care for Children,* August 2001: Paediatric Society of New Zealand and the Board of Paediatrics and Child Health of the Royal Australasian College of Physicians

*Ethical Guidelines: Health Research With Children:* Peart, N and Holdaway, D. NZ Bioethics J, October 2000


*Information and Consent:* Medical Council Statement (April 2002), Medical Council of New Zealand

*Legislative requirements about patient rights and consent:* Medical Council Statement (October 2005), Medical Council of New Zealand

*Medical law in New Zealand:* Peter Skegg, Ron Paterson, General Editors, Brookers Ltd 2006


**Legislation and Regulations**

Alcoholism and Drug Addiction Act 1996
Armed Forces Discipline Act 1971
Care of Children Act 2004
Children, Young Persons and Their Families Act 1989
Code of Health and Disability Services Consumers’ Rights 1996 (A regulation under the Health and Disability Commissioner Act)
Contraception, Sterilisation and Abortion Act 1977
Coroners Act 2006
Crimes Act 1961
Criminal Investigations (Bodily Samples) Act 1995
Criminal Procedure (Mentally Impaired Persons) Act 2003
Health Act 1956
Health and Disability Commissioner Act 1994
Health Information Privacy Code 1994
Human Tissue Act 2008
Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
Judicature Act 1908
Land Transport Act 1998
Mental Health (Compulsory Assessment and Treatment) Act 1992
New Zealand Bill of Rights 1990
New Zealand Public Health and Disability Act 2000
The New Zealand Disability Strategy (2001) Ministry of Health
Protection of Personal Property and Rights Act 1988
Tuberculosis Act 1948

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### Appendix 1

#### Summary of statutory requirements relating to consent

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Relevant Statute/Act</th>
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<tbody>
<tr>
<td>1.</td>
<td><strong>Abortion or other procedure to terminate pregnancy on female of any age</strong></td>
<td>Section 38 of the Care of Children Act provides that a girl of any age is treated as an adult for the purpose of consent, or refusal of consent to, a medical or surgical procedure for the purpose of terminating her pregnancy, by a person professionally qualified to carry it out.</td>
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<tr>
<td>2.</td>
<td><strong>Abortions on persons who lack “mental capacity”</strong></td>
<td>Section 34 Contraception, Sterilization and Abortion Act 1977 permits abortions to be performed on patients who lack the capacity to consent by reason of “mental incapacity” when the circumstances set out in the section are met.</td>
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<tr>
<td>3.</td>
<td><strong>Definition/treatment of alcoholics/drug addicts</strong></td>
<td>Alcoholism and Drug Addiction Act 1996 – A Judge may issue orders for detention and treatment of alcoholics and drug addicts which have to be complied with.</td>
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<td>4.</td>
<td><strong>Treatment of armed forces personnel</strong></td>
<td>Section 72 Armed Forces Discipline Act 1971 provides a range of circumstances where it is an offence for a member of the armed forces to without lawful excuse, refuse or fails to submit him/herself to treatment or procedures as set out in the section after being ordered to do so. Whilst it is an offence not to submit to treatment under this section, this does NOT authorise health professionals to provide the treatment without consent.</td>
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<td>5.</td>
<td><strong>Taking blood samples to detect drink driving offences</strong></td>
<td>Sections 72, 73 and 74 of the Land Transport Act 1998 allows the taking of blood samples from persons attending hospital or doctor's surgery suffering injury as a result of a motor vehicle accident. Special requirements apply. Whilst it is mandatory that a health practitioner take a blood sample if requested by the Police, there is no authority under the Act to use force.</td>
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<tr>
<td>6.</td>
<td><strong>Blood transfusions for persons under 18 years</strong></td>
<td>Section 37 Care of Children Act may provide statutory protection for a health professional who administers a blood transfusion to a child under 18 years without consent in the limited circumstances set out in the section. Administering a blood transfusion to a child without consent is a legally difficult issue. If a person under the age of 18 years or his or her guardian is refusing consent to a blood transfusion refer to Appendix 2.</td>
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<td>7.</td>
<td><strong>Taking blood or bodily samples for the purpose of DNA</strong></td>
<td>The Criminal Investigations (Bodily Samples) Act 1995 provides a statutory regime for obtaining blood or bodily samples for the purpose of DNA profiling from criminal suspects. The Act distinguishes between persons under the</td>
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<td><strong>profiling</strong></td>
<td>age of 14 years, children 14 to 17 years, and persons over the age of 17 years. For consent to be valid the requirements set out in the Act must be followed. The Act also sets out the circumstances when a bodily sample may be taken without the person or child’s guardian(s) consent.</td>
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<td><strong>8. Suspected child abuse or neglect</strong></td>
<td>Under Sections 49 and 53 Children, Young Person and Their Families Act the Family Court has the power to order medical examinations and reports in respect of children and young persons. In limited circumstances social workers also have the power to require medical examinations. Where medical examinations are arranged by a social worker, reasonable efforts should be made to obtain the consent of the parent or guardian. Examinations can be made where such consent is not obtained after reasonable efforts. Where the examination includes an internal examination of the genitals or anus, the child or young person must consent, unless his or her age or level of maturity makes it impracticable to do so (section 55).</td>
<td></td>
</tr>
</tbody>
</table>
| **9. Children and young persons with intellectual disabilities under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (“ID (CCR) Act”)** | For the purposes of the ID (CCR) Act “child” and “young person” are given the same meaning as under the Children, Young Person and Their Families Act. That is a child is a person under the age of 14 years and a young person is a person of or over the age of 14 years but under 17 years, but does not include any person who is or has been married.

The ID (CCR) Act defines the circumstances in which persons may be subjected to compulsory assessment, care and rehabilitation for intellectual disability (section 37). A care recipient may be given medical treatment without the care recipient’s consent only if the treatment is authorised by section 62. A guardian’s consent to medical treatment is necessary if the child or young person is under the age of 16 years and is unable to consent. The exception to this is treatment authorised under section 62. |
| **10. Children and young persons under the Mental Health (Compulsory Assessment and Treatment) Act (“MH (CAT) Act”)** | For the purposes of consent to assessment and treatment under the MH (CAT) Act a child or young person is a patient or proposed patient who is under the age of 17 years (section 85). Once a person has attained the age of 16 years, a parent or guardian cannot consent to any assessment or treatment for mental disorder on behalf of the person (section 87). Therefore once a person is 16 years or older they must be treated as an adult for the purposes of consenting to assessment or treatment of any mental disorder.

This means that even if the young person is incompetent it will not be sufficient for a parent or guardian to give consent. Where the person is incompetent or refuses treatment for mental disorder under the MH (CAT) Act, the young person must be managed in the same way as an adult who is incompetent or refuses assessment or treatment under the MH |
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<td><strong>11. Civil proceedings</strong></td>
<td>Section 100 Judicature Act 1908 provides that the High Court can order that a person submit to a medical examination where the physical or mental condition of a person party to the proceedings is relevant to any matter in question. Whilst the person ordered to attend the examination is obliged to attend and cooperate, the provision does not authorise an examination without the person’s consent. Rather a failure to attend without reasonable cause empowers the Court to stay or strike out the proceedings concerned.</td>
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<td><strong>12. Contraceptive advice and treatment</strong></td>
<td>Under the Contraception, Sterilisation and Abortion Act 1977 a health practitioner may administer contraception if it is in the best interests of the child to do so and the parents or guardians give consent on behalf of the incompetent female child. However, if a young female patient is mentally subnormal and the parents or guardians refuse to consent to contraceptive treatment against the advice of the health practitioner, legal advice should be sought. Mentally subnormal is defined in Section 4 Contraception, Sterilisation and Abortion Act 1977.</td>
</tr>
<tr>
<td><strong>13. Director General of Social Welfare has been appointed as sole guardian of the child</strong></td>
<td>Under section 110(2)(a) Children, Young Persons and Their Families Act 1989, where the Director-General has been appointed as a sole guardian of a child consent can only be given by the Director General. A child 14 years and over may apply to the court to overturn a refusal of consent by the Director General in respect of important matters that affect the child (section 116).</td>
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<tr>
<td><strong>14. Enduring Power of Attorney</strong></td>
<td>Under section 98 Protection of Personal and Property Rights Act 1988 a person may be authorised to give consent for a patient who is mentally incapable under an enduring power of attorney in relation to personal care and welfare. The attorney will have the powers appointed to them under the power of attorney document. Unless it is an emergency, where an attorney has been appointed, the consent of the attorney must be obtained before carrying out any treatment on a patient, provided that the proposed treatment falls within the ambit of the attorney’s jurisdiction under Act.</td>
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<td><strong>15. Examinations of children in public and private schools</strong></td>
<td>Section 125 Health Act 1956 permits certain health professionals to enter schools and child care centres to examine children (subject to the request of school in case of private schools). The health professional may examine any child at the school or centre. The prior consent of the parents is not required. If a child is competent to consent then a health professional must obtain the child’s consent before administering treatment.</td>
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<td><strong>16. Guardianship of the</strong></td>
<td>A court may appoint itself a child’s guardian and authorise a</td>
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*Informed consent (adults and children)*

**CPP CON-07**

*Date printed from Silent One 06/12/2016*
| child vested in the Court | person, such as the child’s medical practitioner, to act as the court’s agent either generally or for a particular purpose (section 31 Care of Children Act). Once a court has been appointed a guardian of the child it, or its agent, can make decisions with respect to the medical treatment that the child receives. The child must not be married or living in a de facto relationship. |
| Collection or use of human tissue from a body, use for a secondary purpose after the donor's death, and collection of non-health-care tissue for donor analysis and analysis of such tissue. | The Human Tissue Act 2008: (a) requires (under section 19), unless done for a purpose specified in section 20, informed consent for the following: (i) collection or use of human tissue that is, or is collected from, a body: (ii) collection of non-health-care tissue for donor analysis: (iii) donor analysis of non-health-care tissue: (iv) use for a secondary purpose, after the donor's death, of human tissue collected from a living individual; and (b) makes it an offence to collect or use tissue if the informed consent required has not been given (sections 22-24); and (c) imposes other requirements for and restrictions on collection or use of human tissue; and (d) provides for related matters; and (e) repeals and replaces (with modified provisions)— (i) the Human Tissue Act 1964; and (ii) Part 3A (trading in human blood and controlled human substance) of the Health Act 1956. |
| 17. Treatment of infectious/venereal disease | Provisions in the Health Act 1956 give certain health professionals rights to; enter any premises and examine any person believed to be suffering from or recently exposed to an infectious disease, isolate a person who is likely to spread an infectious disease, and forbid a person from leaving a district or place until certain conditions are met. Section 88(1) Health Act 1956 makes it mandatory for persons suffering from venereal diseases to undergo treatment. Section 90(10) requires parents or guardians of children suffering from venereal disease to make them available for treatment. However, these provisions in the Health Act do not preclude the requirement for informed consent. It is still up to the person or the child’s guardian to consent to treatment even though a failure to do so will constitute an offence under the Act. |
18. Persons subject to compulsory assessment, care and rehabilitation under the **Intellectual Disability** (Compulsory Care and Rehabilitation) Act 2003 (“ID (CCR) Act”)

The ID (CCR) Act defines the circumstances in which persons may be subjected to compulsory assessment, care and rehabilitation for intellectual disability (section 37). A care recipient or potential care recipient is required to accept an assessment examination by a specialist assessor designated under section 32(b) to ascertain whether the proposed care recipient has an intellectual disability and is in need of compulsory care.

The Act sets out the circumstances when restraint may be used and when a care recipient may be placed in seclusion. A care recipient may be given medical treatment without the care recipient’s consent only if the treatment is authorised by section 62.

19. **Mentally ill persons**

Under the MH (CAT) Act, a person who is required to undergo assessment in terms of Part I of the Act or under an Order for compulsory treatment in terms of Part II has no right to refuse treatment for the person’s mental disorder for the first month duration of that order.

20. **Post-Mortems**

Under the Coroners Act 2006 the Coroner may require a post-mortem, in certain circumstances. The deceased family may have a right to object to the post-mortem (sections 33 – 35).

21. **Offence likely to cause immediate/serious injury to person/property**

Section 41 the Crimes Act 1961 allows restraint without consent where there is the likelihood of suicide or an offence likely to cause immediate/serious injury to the person or property of anyone.

22. **Examination and treatment of persons with Tuberculosis**

Section 9 of the Tuberculosis Act 1948 empowers a Medical Officer of Health to require a person refusing/failing to undergo an examination to do so.

Under section 16 of the Tuberculosis Act 1948, a District Court Judge may make an Order detaining a TB patient in hospital for specified time to undergo treatment.

23. **Welfare Guardians**

The Protection of Personal Property Rights Act 1988 allows the Court to appoint a Welfare Guardian to make decisions relating to aspects of the personal care and welfare of a person who lacks capacity to make or communicate a decision.

Unless it is an emergency, where a welfare guardian has been appointed, the consent of the welfare guardian must be obtained before carrying out any treatment on a patient, provided that the proposed treatment falls within the ambit of the welfare guardian’s jurisdiction under the Court order.

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**Appendix 2**

**Blood and blood products**
Every patient who is a potential recipient of blood or blood products (or the patient’s legal representative) should be given a copy of the appropriate NZ Blood Service information brochure. This brochure contains details of the appropriate uses, risks and unwanted effects of the blood component or blood products which are being considered for use. It is important that the patient (or the patient’s legal representative) has time to read the brochure, then is given the opportunity to discuss any queries they have with their doctor. As with all medical and other treatments, informed consent must be obtained before treatment is given, except in unexpected emergency situations.

As part of the process of informed consent for transfusion of blood or blood products, patients should be advised of any reasonable alternatives to transfusion of volunteer donated blood, if there are any. In some situations it may be an option for the patient’s own blood to be collected before a planned surgical procedure and administered to the patient either during or after the procedure if necessary. Even though informed consent is a process, at the end it must be documented to acknowledge that the process has occurred.

Consent for transfusion of blood or blood products must be in writing on the “Consent to Treatment/Procedure” Form. Whilst the ultimate responsibility for obtaining consent for the transfusion lies with the doctor who has prescribed the transfusion for the patient, this responsibility is often delegated to another health professional attending the patient. Documentation regarding what information was disclosed to the patient by the doctor obtaining the consent must be clearly recorded in the patient’s record.

Where a series of transfusions are required for a course of treatment and the need for repeated transfusions is part of the information disclosure prior to obtaining the patient’s informed consent, one consent will cover the course of treatment.

In most medical treatments, informed consent to the overall treatment program will be obtained at the outset. Where transfusion may be needed during surgery, the Consent to (Planned Course of) Treatment/Procedure(s)” Form should also indicate informed consent for transfusion of blood or blood products has been given.

Is a transfusion really necessary?

Health professionals should always carefully consider alternatives to blood transfusion, and a transfusion of blood or blood products should only be given when the benefits to the patient outweigh the risks.

Apart from the patient’s own blood, there is seldom a satisfactory substitute for donated human blood when it is needed. The alternatives are high-cost products only suitable for a small number of conditions, e.g. synthetic Factor VIII, erythropoetin.

If the patient refuses to have a blood transfusion when needed, the risks to the patient’s health are likely to increase. The outcome for the patient of many types of surgery and treatments for cancer is much less favourable without utilisation of blood or blood products.

Clinical situations

Adult patients – (18 years and over)
In an emergency where the patient cannot give consent, blood products may be given to preserve life or prevent further deterioration of clinical condition. Once the emergency situation passes further treatment cannot be given without the consent of the patient.

If there is prior knowledge that the patient would not agree to blood transfusion (for example, an advance directive) this must be respected unless the health professional has reasonable grounds for questioning the validity of the directive. The statutory provision in the Care of Children Act discussed below, does not apply to a person over 18 years.

In other situations (i.e. non emergency situations) when a competent adult patient makes a decision to refuse blood or blood products for any reason, this decision must be respected. (See also section, Advance Directives, on page 17). The responsible health professional must ensure that the patient fully understands the implications this refusal may have on the clinical outcome, and that the decision is not the result of any outside influence or coercion.

In the case of an incompetent adult a welfare guardian or person with enduring power of attorney for personal care and welfare cannot refuse consent to standard medical treatment intended to save the patient's life or to prevent serious damage to a patient's health.

Where the health professional is concerned about their legal or ethical responsibility in a particular situation, legal advice should be sought from the in-house legal advisor.

Children under 18 years

Administering a blood transfusion to a child without consent, or where a competent child and his or her guardians disagree is a legally difficult issue. If a person under the age of 18 years or his or her guardian is refusing consent to a blood transfusion, legal advice from C&C DHB's in-house legal advisor should be sought immediately.

Section 37 of the Care of Children Act 2004 may protect a health practitioner who has administered a blood transfusion to a person under the age of 18 where there is a lack of consent from civil, criminal or disciplinary proceedings in the limited circumstances set out in the section. That is:

(a) in the reasonable opinion of the health professional the transfusion was necessary to save the life of the patient or to prevent permanent injury to mental or physical health or to save the patient from prolonged and avoidable pain and suffering; and

(b) either a reasonable attempt had been made to obtain consent, or it was necessary to administer the transfusion promptly and therefore impracticable to obtain consent; and

(c) in all the circumstances it was reasonable to administer the transfusion

In considering the "reasonableness" of the health professional’s opinion the Judge must take into account the following:

- the condition of the patient before the transfusion;
- circumstances in which it was administered;
• whether it was practicable to consult other health professionals;
• opinion of other health professionals consulted; and
• all other relevant circumstances (section 37(4)).

Section 37 does not in any way affect the health professional’s duty to seek prior consent with the assistance of the Court where time and circumstances permit.
Appendix 3

Clinical teaching and research

Introduction

The rights in the Code of Rights apply to occasions when a patient is participating in, or it is proposed that a patient participate in, teaching or research (Right 6(1)(d) and(9)). It is important that patients are informed generally that teaching is an essential part of the provision of health care services, and that teaching includes training of providers. A paramount consideration must always be the welfare and interests of the patient.

As part of the teaching process, students are required to gain information regarding patients either by direct questioning or by accessing the patient’s clinical file. It is thus important to remember that the patient’s rights extend to knowing for what purpose this information is being used, (e.g. written assignment, tutorial or oral presentation at a meeting), and also what steps have been taken to preserve the privacy of the information, such as de-identifying.

In the context of a teaching hospital, it may not be necessary to obtain specific informed consent for every stage of the teaching process. What is necessary is that the patient (or the person legally entitled to consent on behalf of the patient) is informed that he or she is receiving treatment in a teaching hospital and that junior staff or students under supervision may carry out parts of the patient’s management and treatment, and will have need to access the patient’s clinical record. The patient should also be informed that he or she has the right to ask questions, to have those questions answered honestly and accurately, and can refuse to be involved in training at any stage.

Good quality experience for students is based on a three-way partnership between:

- the patient who agrees to be part of the teaching/learning process;
- teaching staff;
- the student.

An effective health care setting needs a continuing supply of qualified staff. An essential requirement for training health care professionals is access to practical experience that is well planned and properly supervised.

Informed consent for clinical teaching and research

Teaching

(a) If any health professional, student or other person attends a procedure as an “observer” this is a teaching situation. Observers (including students) are defined as those additional to the normal health professionals immediately involved in the procedure, and staff directly concerned with the ongoing care.

(b) Every patient has the right to decide whether they agree to or decline to be cared for, interviewed by, examined or have other specific procedures carried out on them by a health professional student. If the patient is of diminished capacity it
is important that the patient is involved in the decision to participate or not according to the level of their competence.

(c) Patients must be informed of, and consent to, any proposed participation in teaching, including the reason for an observer’s or trainee’s presence and/or participation in the patient’s care. This extends to observational teaching and is not limited to situations where the trainee is undertaking an interventional procedure.

(d) C&C DHB requires that consent is obtained in writing:

- where a student is to undertake an examination or a procedure under the direct supervision of a registered health professional whilst the patient is under general anaesthetic or sedation; and

- where clinical video or photographic recordings (including digital photographs) are taken for education or research purposes.

(e) Patients have the right to know the name and professional status of any person who wishes to interview them and/or examine them, or carry out specific treatment or investigative procedures for teaching or research purposes.

(f) If a student is to undertake an examination or a procedure under the direct supervision of a registered health professional while the patient is under general anaesthetic or sedation, it is courteous that where possible the student should meet with the patient before the examination or procedure.

(g) Educators must obtain a patient’s consent if they wish the patient to be involved in teaching or clinical demonstration sessions, and also explain precisely what will be involved and how many students will be present. This must be done when the students are not present, to avoid placing undue pressure on the patient. Patients have the right to withdraw from the teaching session or research project at any stage, and must receive a clear prior assurance that refusal to participate will not jeopardise their care in any way.

(h) Video and sound recordings of patients and clinical photographs, including digital photographs, are to be used for teaching purposes, only with the written informed consent of the patient involved or the person legally entitled to consent on the patient's behalf. These recordings and photographs should be non-identifying. The clinical video recordings and photographs must only be obtained by an authorised C&C DHB photographer after receipt of a C&C DHB photographic request form or health professional, with the written consent of the patient or the person legally entitled to consent on the patient’s on the consent form. These records will be kept in the patient’s clinical record or in the Wellington School of Medicine and Health Sciences archives indefinitely, unless the patient or the person entitled to consent on behalf of the patient instructs otherwise.

(i) The patient must be aware that they are free to stop the recording at any time, and that they are entitled to view it if they wish, before deciding whether to give consent to its use.

(j) Recordings of patients may be shown or played only for the purposes for which
they were made and for which consent was granted. The requirements of the Privacy Act and the Health Information Privacy Code must be observed.

(k) A health professional may wish to make a video or sound recording or take a clinical photograph for education, publication or research purposes, but the patient is temporarily unable to give or refuse consent. In this case, it is permissible for the recording/photograph to be made, but the patient's consent must be obtained as soon as the patient regains capacity. The recording or photograph should not be used until consent has been obtained. If the patient's refuses to consent to the recording or photograph must be destroyed.

(l) Special requirements apply for patients who come under the Mental Health (Compulsory Assessment and Treatment) Act and Intellectual Disability (Compulsory Care and Rehabilitation) Act.

Research

(a) Staff and students involved in research activities and clinical trials must have received authorisation from the Ethics Committee and Management, and must work under the supervision of their teacher or research project leader.

(b) Students and researchers have a professional and legal responsibility to ensure that all personal information acquired by them about a patient remains confidential.

(c) Informed consent is required prior to a patient participating in research. If the research is changed or amended once the patient’s consent has been obtained the health professional should renew the patient's consent.

(d) Any patient taking part in medical or scientific research must have given written informed consent (Right 7(6)). The patient must be adequately informed of the aims, methods, anticipated benefits and potential hazards of the research.

(e) Patients must not feel pressured to take part in research and must be aware that they can withdraw from the research at any time without their care being compromised.
Appendix 4

Code of Health and Disability Services
Consumers’ Rights 1996

1. Consumers have rights and providers have duties –

   (1) Every consumer has the rights in this Code of Rights.
   (2) Every provider is subject to the duties in this Code of Rights.
   (3) Every provider must take action to:
       (a) Inform consumers of their rights; and
       (b) Enable consumers to exercise their rights.

2. Rights of consumers and duties of providers –

The rights of consumers and the duties of providers under this Code of Rights are as follows:

Right 1: Right to be treated with respect

   (1) Every consumer has the right to be treated with respect.
   (2) Every consumer has the right to have his or her privacy respected.
   (3) Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Maori.

Right 2: Right to freedom from discrimination, coercion, harassment, and exploitation.

Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial, or other exploitation.

Right 3: Right to dignity and independence

Every consumer has the right to have services provide in a manner that respects the dignity and independence of the individual.

Right 4: Right to services of an appropriate standard

   (1) Every consumer has the right to have services provided with reasonable care and skill.
   (2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
   (3) Every consumer has the right to have services provided in a manner consistent with his or her needs.
   (4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.
   (5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.
Right 5: Right to effective communication

(1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.

(2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

Right 6: Right to be fully informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including:
   (a) An explanation of his or her condition; and
   (b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and
   (c) Advice of the estimated time within which the services will be provided; and
   (d) Notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and
   (e) Any other information required by legal, professional, ethical, and other relevant standards; and
   (f) The results of tests; and
   (g) The results of procedures.

(2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

(3) Every consumer has the right to honest and accurate answers to questions relating to services, including questions about:
   (a) The identity and qualifications of the provider; and
   (b) The recommendation of the provider; and
   (c) How to obtain an opinion from another provider; and
   (d) The results of research.

(4) Every consumer has the right to receive, on request, a written summary of information provided.

Right 7: Right to make an informed choice and give informed consent

(1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code of Rights provides otherwise.

(2) Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.

(3) Where a consumer has diminished competence, that consumer retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence.
(4) Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where:
   (a) It is in the best interests of the consumer; and
   (b) Reasonable steps have been taken to ascertain the views of the consumer; and
   (c) Either:
      (i) If the consumer's views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent; or
      (ii) If the consumer's views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.

(5) Every consumer may use an advance directive in accordance with the common law.

(6) Where informed consent to a health care procedure is required, it must be in writing if:
   (a) The consumer is to participate in any research; or
   (b) The procedure is experimental; or
   (c) The consumer will be under general anaesthetic; or
   (d) There is a significant risk of adverse effects on the consumer.

(7) Every consumer has the right to refuse services and to withdraw consent to services.

(8) Every consumer has the right to express a preference as to who will provide services and have that preference met where practicable.

(9) Every consumer has the right to make a decision about the return or disposal of any body parts or bodily substances removed or obtained in the course of a health care procedure.

(10) No body part or bodily substance removed or obtained in the course of a health care procedure may be stored, preserved, or used otherwise than –
    (a) with the informed consent of the consumer; or
    (b) for the purposes of research that has received the approval of an ethics committee; or
    (c) for the purposes of 1 or more of the following activities, being activities that are each undertaken to assure or improve the quality of services:
       (i) a professionally recognised quality assurance programme:
       (ii) an external audit of services:
       (iii) an external evaluation of services.

Right 8: Right to support

4 The regulations define “ethics committees” as any ethics committee established by, or appointed under, an enactment, or approved by the Director-General of Health.
Every consumer has the right to have one or more support persons of his other choice present, except where safety may be compromised or another consumer’s rights may be unreasonably infringed.

**Right 9: Rights in respect of teaching or research**

The rights in this Code of Rights extend to those occasions when a consumer is participating in, or it is proposed that a consumer participate in, teaching or research.

**Right 10: Right to complain**

(1) Every consumer has the right to complain about a provider in any form appropriate to the consumer.

(2) Every consumer may make a complaint to:

   (a) The individual or individuals who provided the services complained of, and
   (b) Any person authorised to receive complaints about that provider; and
   (c) Any other appropriate person, including:
       (i) An independent advocate provided under the Health and Disability Commissioner Act 1994; and
       (ii) The Health and Disability Commissioner.

(3) Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.

(4) Every provider must inform a consumer about progress on the consumer’s complaint at intervals of not more than one month.

(5) Every provider must comply with all the other relevant rights in this Code of Rights when dealing with complaints.

(6) Every provider, unless an employee of a provider, must have a complaints procedure that ensures that

   (a) The complaint is acknowledged in writing within five working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period; and
   (b) The consumer is informed of any relevant internal and external complaints procedures, including the availability of:
       (i) Independent advocates provided under the Health and Disability Commissioner Act 1994; and
       (ii) The Health and Disability Commissioner; and
   (c) The consumer's complaint and the actions of the provider: regarding that complaint are documented; and
   (d) The consumer receives all information held by the provider that is or may be relevant to the complaint.
(7) Within 10 working days of giving written acknowledgment of a complaint, the provider must:
   (a) Decide whether the provider:
       (i) Accepts that the complaint is justified; or
       (ii) Does not accept that the complaint is justified; or
   (b) If it decides that more time is needed to investigate the complaint:
       (i) Determine how much additional time is needed; and
       (ii) if that additional time is more than 20 working days, inform the consumer of that determination and of the reasons for it.

(8) As soon as practicable after a provider decides whether or not it accepts that a complaint is justified, the provider must inform the consumer of:
   (a) The reasons for the decision; and
   (b) Any actions the provider proposes to take; and
   (c) Any appeal procedure the provider has in place.

3. Provider compliance –

(1) A provider is not in breach of this Code of Rights if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code of Rights.

(2) The onus is on the provider to prove that it took reasonable actions.

(3) For the purposes of this clause, 'the circumstances' means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

4. Definitions –

In this Code of Rights, unless the context otherwise requires:

'Advance directive' means a written or oral directive:
   (a) By which a consumer makes a choice about a possible future health care procedure; and
   (b) That is intended to be effective only when he or she is not competent:

'Choice' means a decision:
   (a) To receive services:
   (b) To refuse services:
   (c) To withdraw consent to services:

'Consumer' means a health consumer or a disability services consumer; and, for the purposes of rights 5, 6, 7(l), 7(7) to 7(10), and 10, includes a person entitled to give consent on behalf of that consumer:

'Discrimination' means discrimination that is unlawful by virtue of Part 11 of the Human Rights Act 1993:

'Duties' includes duties and obligations corresponding to the rights in this Code of Rights: 'Exploitation' includes any abuse of a position of trust, breach of a fiduciary duty, or exercise of undue influence:
'Optimise the quality of life' means to take a holistic view of the needs of the consumer in order to achieve the best possible outcome in the circumstances:

'Privacy' means all matters of privacy in respect of a consumer, other than matters of privacy that may be the subject of a complaint under Part VII or Part VIII of the Privacy Act 1993 or matters to which Part X of that Act relates:

'Provider' means a health care provider or a disability services provider:

'Research' means health research or disability research:

'Rights' includes rights corresponding to the duties in this Code of Rights:

'Services' means health services, or disability services, or both; and includes health care procedures:

'Teaching' includes training of providers.

5. Other enactments –

Nothing in this Code of Rights requires a provider to act in breach of any duty or obligation imposed by any enactment or prevents a provider doing an act authorised by any enactment.

6. Other rights not affected –

An existing right is not overridden or restricted simply because the right is not included in this Code of Rights or is included only in part.
Appendix 5

Request for Treatment/Procedure(s)

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<tr>
<th>Name</th>
<th>Attach patient label here</th>
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| Description of treatment/procedure(s) |

I understand the nature, benefits and risks of the above treatment and/or procedure(s), I have had explained to me the alternative treatment and/or procedure(s) available, including not having any treatment. I have had the opportunity to ask my questions about the above treatment and/or procedure(s). I am aware that I may ask for more information at any time and that my health information may be used for quality audit purposes.

I agree that if during the treatment/procedure(s) there is an unexpected finding or event additional procedures deemed to be essential might be carried out.

I agree to my blood being taken for testing in the event of a staff member being exposed to my blood or body fluid.

I understand the nature, benefits and risks of receiving blood components/blood products and agree to receiving these if it is clinically necessary and in my own best interests.

I understand and agree that written, electronic, radiographic, video, sound and photographic records may be made and stored, and may be referred to at a later date for teaching purposes and/or for Ethics Committee approved research.

I understand that this treatment is being carried out in a teaching hospital and agree to observation of and participation in my treatment and/or procedure(s) by students under appropriate supervision.

I understand that following this treatment/procedure(s), I may be sedated and should not drive a motor vehicle, operate machinery or potentially dangerous appliances, drink alcohol or make important legal or financial decisions for at least 18 hours afterwards.

I understand that tissue removed during the treatment/procedure(s) may be submitted for pathological examination, kept and referred to at a later date for clinical purposes, audit, teaching and for Ethics Committee approved research. I understand that the tissue may be returned to me if I wish (a Tissue Return Form (CCDMB) or a Body Part Chain of Custody Form (MVCMB) is required).

Signature of patient/parent/guardian/personal care and welfare attorney

Name of health professional

Signature

Designation

The treatment/procedure I intend to perform on is correctly described above.

Name of person performing treatment/procedure(s)

Signature

Designation

Date

Date

Date

Please turn over to add supporting relevant information.
CONSENT - REQUEST FOR TREATMENT/PROCEDURE(S)

Request for Treatment/Procedure(s)

SUPPORTING RELEVANT INFORMATION:

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

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Add additional pages as required
Appendix 6

**Treatment/Procedure(s) Without Consent**

(where the patient lacks capacity to give consent and no other person is legally authorised to give consent)

<table>
<thead>
<tr>
<th>Surname:</th>
<th>First names:</th>
<th>Attach patient label here</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DOB:</th>
<th>M</th>
<th>F</th>
<th>NHI:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**Description of treatment / procedure(s):**

**Purpose of treatment / procedure(s):**

**Patient determined to lack capacity on the basis of: (tick box; more than one category possible)**

- [ ] Pre-existing condition
- [ ] Current illness / injury
- [ ] Therapeutic intervention

Details in medical record

**Does the patient have a person legally authorised to give consent?**

YES [ ] NO [ ]

*If YES, use the REQUEST FOR TREATMENT/PROCEDURE(S) form.*

**ASCERTAINING THE PATIENT’S OR OTHER SUITABLE PERSON’ VIEWS ABOUT PROPOSED TREATMENT/PROCEDURE(S)/RECORDING**

Write details in medical record

1. Is the treatment / procedure(s) in the patient’s best interests? [ ]
2. Have reasonable steps been taken to ascertain the patient’s views on this treatment / procedure(s)? [ ]
3. Is the treatment / procedure(s) in accordance with the patient’s views? [ ]
4. Where it has not been possible to ascertain the patient’s views, have the views of other suitable persons who are interested in the welfare of the patient been sought? [ ]
5. Where the patient’s views or other suitable persons’ views could not be ascertained, this was because of: [ ]

- [ ] Clinical urgency
- [ ] Other suitable persons not available

And a second opinion supports the treatment / procedure(s).

**AUTHORISING DOCTOR**

Taking all matters into consideration, I believe that it is appropriate to proceed with the treatment / procedure(s).

Name: [ ] Signature: [ ]

Date: [ ] Designation: (Registrar or Specialist): [ ]

Please turn over to write extra notes
NOTES

Add additional pages as required
Appendix A

Request for medical examination (Child)

I, .................................................................................................................................................................................. (patient /parent /guardian) request that the following be performed on me / my child / my ward.

..............................................................................................................................................................................

(Name of child / ward if applicable)

Description:
- A medical physical examination
- A genital examination
- An internal vaginal or rectal examination
- The collection of specimens
- Photographs of findings and injuries

I understand the benefits and risks of the above procedures. I have had explained to me the impact of not having them. I am aware that I may ask for more information at any time. I am aware that I may withdraw my consent at any time.

I understand and agree that specimens collected during the procedure may be submitted for pathological and/or forensic examination to be handled and stored according to normal procedures and that the findings will be recorded for legal purposes.

I understand and agree that written and electronic records of the examination may be made and stored confidentially and that this record may be made available to the New Zealand Children and Young Persons' Service and to the Police, for legal and statutory purposes.

I understand and agree that a photographic record may be made of the examination findings, that will be stored confidentially and may be viewed anonymously for the purposes of peer review and teaching.

Signature of patient/ parent/ guardian............................................................ Date..........................

Name of witness during examination .......................................................... Designation..........................

The procedure I intend to perform on ____/____/____ is correctly described above.

Signed: .................................................. Date: ..........................................

(Person performing procedure)

Name: .......................................................... Designation:..........................

Consent obtained by Court Order under CYF&F Act 1989

Judge: .................................................. Court: .................................................. Date: ........................................