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Mr Stephen Lodge
Manager
Legislation Review (Public Health)
Department of Human Services
GPO Box 1670N
MELBOURNE VIC 3001

Dear Mr Lodge

Re: Review of the Health Act 1958 and proposed amendment to Section 120A thereof

Thank you for granting an extra couple of days for the making of this submission. The matters set out in the letter of 29 October from Dr Lester have assisted us in preparation of a submission in relation to Section 120A. That was one of two areas Southern Health proposed to comment upon in response to the request for submissions as part of the review of the Act. We now confine comments on Section 120A to the matters set out below.

Our second area of comment addresses the provisions of the Act commencing at Section 162B which deal with the Consultative Council on Obstetric and Paediatric Mortality and Morbidity. Again, our submission is set out below.

Section 120A

It is my strong suspicion that only a minute percentage of cases involving a refusal to be tested or an inability to consent are ever referred to the Secretary for the making of an Order. There is a range of reasons, of varying validity, for that situation, not the least of which is the concern of those involved in the treatment of a care giver after an incident that it will not be possible to obtain an Order within a time frame which permits the administration of anti-retroviral drugs within the period of maximum effectiveness. Other concerns relate to the possibility of refusal of the request and the consequences to the care giver as well as to the person seeking the Order if, notwithstanding refusal, that person proceeds to test for HIV (in particular) without patient consent. In other instances, despite the availability of written material within most hospitals, medical practitioners remain unaware of Section 120A and simply make adhoc decisions, generally in favour of testing, without reference to more senior and knowledgeable colleagues.

The common feature, in my experience both at Southern Health and previously in private practice advising the majority of major Melbourne hospitals, is that medical practitioners confronted with the situation contemplated by Section 120A wish to do the least harm to the patient who could have transmitted a specified disease while offering the best available protection to the care giver who has been exposed. A great deal of additional difficulty is caused to those practitioners by the inadequate wording of the present legislative provisions which do not address the situation where a patient is unable, by reason of mental and/or physical condition, to either grant or refuse consent. That situation arises quite frequently, particularly in connection with incidents involving patients who are undergoing invasive procedures and are under the influence of prescribed drugs including those used to achieve sedation or anaesthesia. In many such instances, the patient is likely to be able to express a view about consent in 12 or 24 or 36 hours after the incident but that is of no help to those involved in dealing with the aftermath of the incident.

Southern Health submits that the procedure contemplated in paragraph 8 of the notes attached to the letter of 29 October should be introduced in relation to cases where there is actual refusal by a patient and those cases where, by virtue of physical and/or mental incapacity, a patient is unable to give or refuse consent for blood testing. Southern Health agrees that the procedure should be limited to incidents which occur in a hospital and we note the footnote comment as to the definition of "hospital".

Generally, the medical practitioner dealing with an incident of possible exposure to infectious substances wishes to obtain blood for testing and the preliminary results of testing as a matter of urgency. Consequently, it is crucial that persons able to give lawful authorisation for non-consensual testing be readily identifiable, available 24 hours per day and 7 days per week and not necessarily be statutorily required to complete documentation of their decision prior to the carrying out of that testing.

Dealing with the last point first, occasions will arise where the person able to authorise testing is away from the hospital, perhaps at a social function, at home or in a motor vehicle, and does not have statutory forms to hand. To deny a potential "victim" the benefit of testing in such a case would, it is suggested, be a very heavy handed approach. Rather, it is suggested that where the medical practitioner who authorises testing is physically within the hospital in question at the time of authorisation, appropriate documentation should be completed prior to testing. In other cases, documentation should be completed and submitted to the hospital within 24 hours. The availability of both email and facsimile transmission should significantly reduce the real world burden of such a requirement.

The comments attached to the letter of 29 October contemplate, as one possibility, the Chief Executive of a hospital being given power to authorise non-consensual testing by a senior medical officer. Initially, I contemplated suggesting that such medical officers be limited to persons appointed to the hospital and holding specialist, post graduate qualifications at the level of Fellow of a recognised College. However, my enquiries have revealed that even in major Melbourne hospitals, at some times on some days, such a person may not actually be present and available to deal with Section 120A situations.

Consequently, it is suggested that medical practitioners appointed to a hospital and of at least five years' standing (whether in Victoria or elsewhere) should be authorised to approve non-consensual testing. One other option is to nominate persons by position, perhaps in descending order from the Chief Medical Officer down. The difficulty with that approach is that people with similar functions who work in different hospitals have different titles and there are major differences between the medical structures of major hospitals in Victoria. I suggest that the requirement to have had five years' experience strikes a reasonable balance and recognises the seriousness of the decision to be made.

Southern Health supports the requirement that any authorisation for non-consensual testing should be in writing (subject to the time question discussed above) and should comply with the requirements specified under Section 120A (2). It should be possible for an uniform document to be introduced across the public health system which requires "the blanks" to be completed, probably with a copy being submitted to the Department, although that would give rise to other privacy issues, particularly in circumstances where testing for the relevant infectious disease or diseases gave negative results.

The Department may prefer that any person authorising non-consensual testing be a medical practitioner. However, as most of the major, metropolitan health services now have experienced lawyers working as their Corporate Counsel, consideration could be given to permit a legal practitioner of at least five years' standing, who is employed by the hospital in question, to authorise non-consensual testing, in addition to the class of medical practitioners suggested above.

Consultative Council Issues

The Council is established under Section 162C and has the functions specified in Section 162F. The major statutory power of the Council is granted by Section 162G and relates to the mandatory reporting of birth information. There are no other mandatory powers granted.

Section 162F(1)(a), introduced in June 2004, amended the functions of the Council to include the conduct of specified study, research and analysis. Prior to that time, there was a lack of statutory power behind many requests for information routinely made by the Council to public hospitals.

Although the Council now has statutory power to conduct described activities, it has not been given power to mandate compliance with any request for information other than compliance with Section 162G.

Since June 2004, the Council has been lawfully able to request health service provider to provide information to it. Under Section 162FA, a health service receiving such a request is authorised to provide the requested information but is not required to do so and never has been.

Where information is so provided to the Council, the Council has the absolute statutory right to provide that information to a wide range of other bodies including "any.... person or class of persons prescribed for the purposes of" Section 162FB. There is nothing in the Act which limits the ability of any such recipient to deal with or act upon or otherwise utilise any information so provided and the Council itself does not appear to be subject to any form of control in that regard.

On a relatively frequent basis, requests for information are received by public hospitals from the Council which involve substantial breaches of patient privacy and confidentiality if the requested information is provided without patient consent. Such requests often require the supply of identifying personal information without the knowledge of the relevant patients and without the Council seeking to have their consent obtained.

The result is that in each case where non-consensual access to confidential/identifying patient information is requested by the Council, Southern Health is placed in the position (without having any statutory guidelines to assist it in decision making) of having to make a subjective judgment as to whether the interest and rights of persons to whom we owe a fiduciary duty should be overridden by a greater duty to serve that highly amorphous concept – the public interest. As many of our patients and clients are vulnerable and have, at best, a difficult relationship with organisations exercising statutory powers, our decision making is made very difficult indeed.

There is a significant correspondence on this topic held by the Council. Mr Michael Batchelor has details.

It is respectfully submitted that the Act should be amended to specify criteria to be taken into account by a health service provider when determining whether and if so what confidential, identifying patient information should be released to the Council and whether each patient concerned should be retrospectively or prospectively notified of the request and the information supplied or to be supplied, in response. Alternatively, amending provisions could mandate specified circumstances under which specified classes of information are to be made available by health service providers to the Council, without patient consent or knowledge. That way, breach of privacy and confidentiality can quite properly be laid at the feet of the Council rather than being seen by our patients as representing a fundamental betrayal of trust by an organisation which they assumed respected their privacy and the confidentiality of very sensitive/highly personal information provided to it.

I welcome the opportunity to discuss any of these matters with you or with your colleagues.

Yours sincerely



John Snowdon
Corporate Counsel