

VIDS

VICTORIAN INFECTIOUS DISEASES SERVICE

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Dear Dr Goodall

Thank you for the opportunity to reply on behalf of the Victorian Infectious Diseases Service regarding review of the Health Act.

8.4 Incident involving care giver

83 Should the new Act continue to outline the procedures for non-consensual testing orders where consent for testing has been refused?

We believe that the new Act should continue to outline the procedures for non-consensual testing orders where consent for testing has been refused.

Although the situation is not common, the Health Act is still the most appropriate place for such legislation and its provisions are broadly appropriate. We recognise however that the practical aspect of obtaining a blood sample from a reluctant patient is a very difficult thing to achieve, particular in a custodial setting.

84 Should the new act introduce a system for the authorisation of non-consensual testing where consent cannot be given to testing?

Yes. We believe this is an important point as there has been a recurring problem for hospitals in recent years, most often where a patient of unknown HIV or hepatitis status is the source of a needle stick injury when the source patient is confused, unconscious, or not competent. In many cases the patient could not be expected to be legally competent to give the consent until many hours or even days after the event. (For example in the post surgery setting). Non-consensual testing in this situation can have a place where management of the confused unconscious or incompetent patient requires a diagnosis for HIV prior to administration of potentially toxic therapy and it would be inappropriate to obtain consent from a relative (even if they are present). It can be very important for management of the recipient of a needle stick injury to know the HIV status of the source patient, because therapy that may be necessary to be given urgently, is not without serious side effects, even to cause death of the subject.



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We recognise that poorly conceived legislation could threaten the rights of the patient. Whatever solution is found, it should include review of the circumstances of the case by a medically qualified person, preferably not directly involved in the care of either the source patient or the potentially infected care giver. We recognise that there are situations when this could be very difficult in an isolated or remote situation.

We believe the most workable solution would be for the power to approve testing to be nominated within each Hospital as outlined in the Discussion Paper. The advantage of this is that the workload would be distributed and approval can be provided more rapidly. Most importantly, the Medical Officer at the local institution would have responsibility for ensuring that post-test counselling is given at an appropriate time. A potential disadvantage is that the decision is not far removed from the doctors directly involved in the case, and their opinions, rather than objective appraisal of the circumstances may be influential. This could lead to inconsistent application of the process with, or between hospitals, and over-zealous testing of subjects.

It would not be appropriate for decisions to be made by nominees at other hospitals who could not be in a position to ensure appropriate follow up and post-test counselling.

85 Should the provisions of the new Act be extended to beyond the care giver or custodian situation and, if so, to what situations?

This is a very difficult area for all of us. Each situation needs to be considered independently, with initial assessment by a Medical Practitioner, and the same rules would apply. Once again, it would not be appropriate for decisions to be made by nominees of other hospitals who would not be in a position to ensure appropriate follow up and post-test counselling. The option of making contact with an Officer of the Department of Human Services should always be in place so that it can be used if other systems fail.

Yours sincerely



Graham V Brown
Head
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cc P Scown RMH
P Brennan RMH