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An algorithm for managing adults who refuse medical treatment in New South Wales

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Abstract

Objectives: The assessment and management of a patient who refuses medical treatment requires clinical skill, and consideration of the relevant law and the patient's decision-making capacity. Psychiatrists are often asked to advise in these situations. We aimed to develop an algorithm describing the relevant legal pathways to assist clinicians, especially psychiatrists, working in New South Wales (NSW), Australia.
Methods: We reviewed the academic literature on treatment refusal, relevant legislation, judicial rulings and NSW Health policy directives and guidelines. We consulted with clinicians and representatives of relevant tribunals.
Results: We developed an algorithm for managing patients who refuse medical treatment in NSW. The algorithm emphases the evaluation of decision-making capacity and tracks separate pathways depending upon a person's status under the Mental Health Act 2007 (NSW).
Conclusions: The algorithm provides a clear decision tree for clinicians responding to a patient refusing medical treatment in NSW.

Keywords: mental competency, treatment refusal, consent, decision-making, Mental Health Act

When a patient refuses recommended treatment, doctors must carefully consider the validity of that refusal in the context of the patient's expressed views, the consequences of refusal, the acuity and severity of the clinical situation, and the nature of the treatment and the law, which varies from jurisdiction to jurisdiction. This paper considers refusal of medical (as opposed to psychiatric) treatment in Australia's most populous state – New South Wales (NSW).

An understanding of capacity, consent and the relevant legislation is important to preserve patient autonomy – one of the fundamental ethical principles underlying healthcare ethics.[1,2] Ignorance of legal provisions pertaining to treatment refusal can result in delayed access to treatment, unlawful interventions and violations of human rights.

Psychiatric trainees report they lack knowledge and confidence about capacity and mental health and guardianship legislation, reflecting gaps in training on these matters.[3,4] Recently there has been increased interest in capacity and treatment refusal in the context of mental illness, as a result of new or amended mental health legislation in every Australasian jurisdiction except the Northern Territory and New Zealand.[5,6]

We aimed to develop an algorithm to assist clinicians to follow the most appropriate pathway when managing a patient refusing medical or surgical treatment. To keep the algorithm simple, we elected not to cover the treatment of persons under 18 years, and a variety of uncommon treatments that have their own legal frameworks, such as abortion, treatments likely to cause infertility, treatments given in the context of research,

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the compulsory treatment of some infectious diseases, treatments given in forensic settings and end-of-life treatments that do not contribute to the person's health and well-being. When these situations arise, clinicians should seek specialist advice.

Methods

We reviewed the literature pertaining to the assessment and management of refusal of medical treatment using PubMed and reference lists of identified articles. We also reviewed relevant NSW Health policy directives and guidelines, including the NSW Mental Health Act 2007 (MHA), the NSW Guardianship Act 1987 (GA) and other relevant legislative instruments. We discussed the algorithm with the NSW Mental Health Review Tribunal (MHRT), the Guardianship Division of the NSW Civil and Administrative Tribunal (NCAT) and the NSW Ministry of Health, and incorporated feedback from these organisations and our consultation–liaison psychiatry team into the final algorithm.

Results

We produced a one-page decision tree (see Figure 1). The main points from the flow chart are elaborated in the following sections.

Note that the first step when a patient refuses a suggested intervention is to ensure that a clear explanation of the treatment has been provided, and to try to reach some negotiated position acceptable to the patient.

Decision-making capacity

At common law, an adult (aged 18 years or over) is presumed to have decision-making capacity with respect to medical decisions.[7] NSW is unique in Australasia in that the legal presumption of capacity has been lowered by statute to 14 years,[8] but we will restrict our considerations here to adults. The presumption of capacity can be rebutted if it can be shown that the person is unable to comprehend or retain the information material to the decision, or unable to use and weigh that information to come to a decision.[7]

A determination of a person's decision-making capacity can only apply to a specific decision, at a specific time. A person should not be deemed to lack capacity unless all reasonable steps have been taken to support the person in making the decision. The information must be given in simple language. The person should have sufficient time and have the assistance of friends or family if desired and practicable.[6]

Importantly, with only limited exceptions, a competent adult's refusal of medical treatment must be respected, even if that refusal is likely to result in physical harm or even death.[7]

MHA status

Hospital patients who are subject to the MHA fall into one of four categories (see Table 1).

In terms of consent for medical treatment, the law treats a voluntary patient like any other patient in the hospital; however, mentally disordered persons, assessable persons and involuntary patients are treated differently depending on the presence or absence of decision-making capacity and the treatment being considered.

Emergency treatment for people not subject to the MHA and voluntary patients

The processes for giving medical treatment to people who lack decision-making capacity are governed by the GA and common law. When a medical practitioner cannot obtain a person's consent for treatment because decision-making capacity is absent, and failure to provide urgently required treatment will endanger the person's life, cause significant pain or serious damage to health, treatment may be given without consent if it is not practicable to obtain substitute consent and there is no reason to believe that the person would have refused treatment if had he or she had been competent (s 37).[9]

Emergency treatment of involuntary patients and assessable persons

Assessable persons, who lack decision-making capacity, may be given emergency treatment in accordance with the GA provisions described in the previous section.[9] Two sections of the MHA – ss 84 and 190(2) – appear to raise the possibility that an authorised medical officer might be able to provide treatment without consent to an assessable person, even over a competent objection, if the authorised medical officer thought the treatment "fit" (s 84) to provide protection against "serious physical harm" (s 190(2)).[10] The better view, legally and in terms of good practice, is that these provisions are not sufficiently clear to provide a power to doctors to override a competent objection to non-psychiatric treatment. In any case, they should not be relied on for this purpose without a court order.

The relevant provisions with respect to emergency treatment for involuntary patients depend upon whether the emergency treatment involves a "surgical operation" or not. Surgical operations include not only surgery as usually understood, but also "the administration of an anaesthetic for the purpose of medical investigation" (s 98).[10]

Emergency surgery for involuntary patients

If an involuntary patient requires emergency surgery to "save the patient's life or to prevent serious damage to

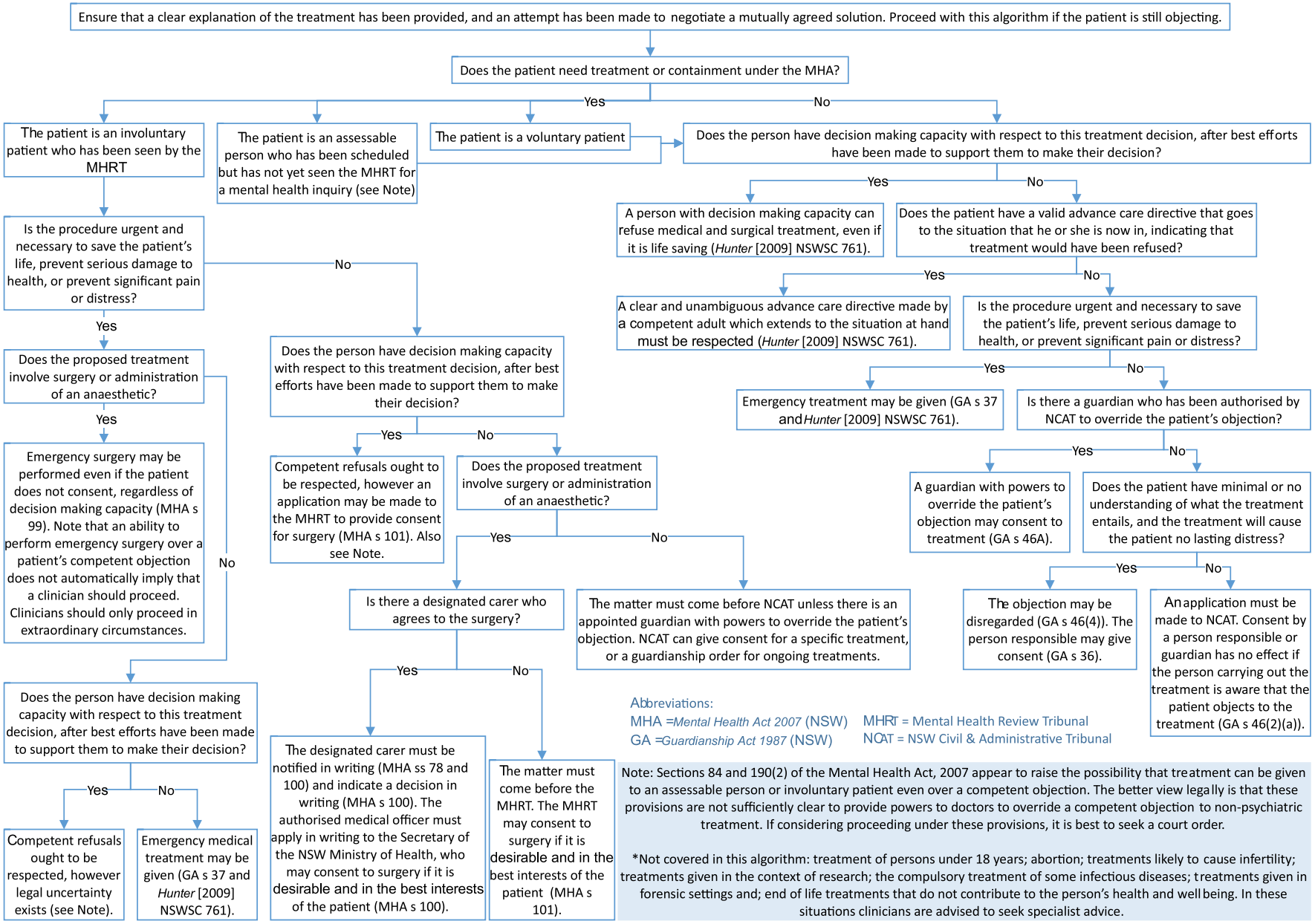

Figure 1. Algorithm for patients refusing medical treatment (NSW).*

Table 1. Status under the Mental Health Act

Status	*Definition*
Mentally disordered persons	"Mentally disordered persons" may be detained in hospital for a short time (s 31), if they are believed to be "mentally disordered" as per s 12 and 15 by two authorised medical officers or accredited persons and at least one of whom is a psychiatrist (ss 27, 27A).
Mentally ill persons	Patients who are assessed as "mentally ill persons" as per ss 12 and 14 at a mental health inquiry before the Tribunal.
Assessable persons	"Assessable persons" are patients who are detained in a declared health facility as per ss 12, 14, 27 and 27A and must be assessed by the Tribunal at a mental health inquiry (s 17).
Voluntary patients	Voluntary patients are inpatients who have been admitted at their own request (s 5) or at the request of a guardian (s 7).

Table 2. Relevant forms for involuntary patients

Form name	*URL (accessed November 2017)*
Notification to designated carer or principal care provider of emergency surgery	http://www.mhrt.nsw.gov.au/assets/files/mhrt/pdf/Notif%20to%20Des%20Carer%20of%20emergency%20surgery%20invol%20patient%20Final%20update%20August%202015.pdf
Notice to tribunal of emergency surgery	http://www.mhrt.nsw.gov.au/assets/files/mhrt/pdf/Notice_EmergencySurgery_Involuntarypatient_Aug15.pdf
Notice to designated carer of proposed surgical operation	http://www.health.nsw.gov.au/mentalhealth/Documents/Legislation/nh700102A.pdf
Decision of designated carer in respect of proposed surgical operation	http://www.health.nsw.gov.au/mentalhealth/Documents/Legislation/NH606705a.pdf
Application for consent to surgical operation	http://www.health.nsw.gov.au/mentalhealth/Documents/Legislation/nh606701a.pdf
Notice to designated carer of an involuntary patient of application to Mental Health Review Tribunal for consent for proposed surgical operation	https://www.mhrt.nsw.gov.au/files/mhrt/pdf/N3_NH700093A%20Notice%20to%20PCP%20of%20proposed%20surgical%20operation.pdf

the patient's health or to prevent the patient from suffering or continuing to suffer significant pain or distress", but the patient cannot, or does not, consent, then an authorised medical officer may give written consent for the operation in accordance with the MHA, regardless of the patient's decision-making capacity (s 99(1)).[10] Of course, an ability to perform even emergency surgery over a patient's competent objection, does not automatically imply that a doctor should so proceed, and clinicians should consider proceeding only in extraordinary circumstances. If emergency surgery is performed, the designated carer, the principle care provider and the MHRT must be notified in writing as soon as practicable afterwards (ss 78(1)(f) and 99(4)) (see Table 2).[10]

Emergency medical treatment for involuntary patients

Involuntary patients who lack decision-making capacity may be given emergency medical (non-surgical) treatment under the GA provisions described previously.[9] With respect to competent refusals, the two sections of the MHA (84 and 190(2)) again raise the possibility that an authorised medical officer might be able to provide emergency medical treatment without consent, even over a competent objection.[10] The same legal uncertainty arises, however, and, again, if a clinician felt that treatment despite a competent refusal were justified, we strongly recommend seeking legal advice.

Non-emergency treatment for people not subject to the MHA and voluntary patients

As noted above, if a patient is not subject to the MHA, or a voluntary patient competently refuses treatment, that refusal must be respected, even if it will endanger the patient's life. If a patient refusing treatment lacks decision-making capacity, an application must be made to the Guardianship Division of NCAT to authorise a guardian to override the patient's objection (s 46A) or to seek consent directly from the Tribunal (ss 44 and 45).[9] If, however, the patient incompetently refusing treatment is doing so with "minimal or no understanding of what the treatment entails" and the treatment will cause no more than "reasonably tolerable" and "transient" distress, the patient's person responsible may consent to the treatment on the patient's behalf (s 46(4)).[9]

Non-emergency surgery for involuntary patients

If an involuntary patient refuses surgery, the Secretary of the NSW Ministry of Health (or his or her delegate) or the MHRT may provide consent in accordance with the MHA (ss 100 and 101). If there is a designated carer who agrees to the surgery and the patient lacks decision-making capacity, the process can proceed through the Secretary. The designated carer must be notified in writing, indicate their decision in writing and the authorised medical officer must apply to the Secretary in writing (see Table 2).

If the patient has no designated carers, or the designated carers do not agree to the surgery, or the patient is competently refusing the surgery, an application may be made to the MHRT to provide consent (s 101). Again, though, an ability to go ahead with surgery over a patient's competent objection does not imply that a doctor should take that option, and clinicians should only consider proceeding in extraordinary circumstances.

Discussion

The idea of the algorithm was well received by mental health and non-mental health staff within our hospital. Trainees felt it greatly simplified the complex pathways involved. The algorithm can be printed and used in emergency departments, medical wards and mental health settings to assist clinicians in NSW.

Conclusion

The algorithm simplifies the pathways pertaining to patients who refuse treatment in NSW. Similar work could be undertaken in other jurisdictions and routinely incorporated into medical education at undergraduate and postgraduate levels.

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