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LINTON, C.E. Consent to treatment for psychiatric patients
Footnotes

FOOTNOTES

1. *The Liberal Imaginations: Essays on Literature and Society* (Secker & Warburg, London, 1951).

2. Committed psychiatric patients under the Mental Health Act 1969.

3. Heuston *Salmond on Torts* (18 ed., Sweet and Maxwell, London, 1981), 113.

4. Technically this is the tort of assault. Assault and battery generally occur together, an apprehension of contact usually followed by an actual physical contact.

5. *Schlaendorff* v. *Society of New York Hospital* 211 N.Y. 125, 129; 105 N.E. 92, 93 (1914) per Cardozo J.

6. No injury is done to one who consents.

7. *Bravery* v. *Bravery* [1954] 1 WLR 1169.

8. *Chatterton* v. *Gerson* [1981] 1 All E.R. 257

9. See for example *Marshall* v. *Curry* [1933] 3 DLR 260; *Mulloy* v. *Hop Sang* [1935] 1 WWR 714; *Murray* v. *McMurchy* [1949] 2 DLR 442. There are comparatively few English authorities litigated on the basis of consent in the medical relationship.

10. Crimes Act 1961, s.196.

11. See definition of "assault" in s.2.

12. Public policy limits the defence of consent. No person can license another to commit a crime *R* v. *Donovan* [1934] 2 KB 498, 507. An individual therefore cannot consent to his own death; killing another in a fight for example would be murder. Neither can he lawfully consent to bodily harm, unless justified in the public interest. *Attorney General's Reference* (No. 6 of 1980) [1981] 2 All E.R. 1057.

13. Devlin *Samples of Law Making* (Oxford University Press, London, 1962), 87.

14. *Attorney General's Reference* (No. 6 of 1980) supra n. 12.

15. *Reibl* v. *Hughes* (1977) 78 DLR (3d) 35, 41. (a persuasive burden).

16. Speller *Law of Doctor and Patient* (H.K. Lewis & Co; London 1973) 16.

17. Discussed later in Part I.

18. See Adams *Criminal Law and Practice in New Zealand* (2 ed., Sweet & Maxwell, Wellington, 1971) para. 594.

19. Idem.

20. Adoption of the narrower interpretation would mean, in effect, that while s. 61A permitted consensual, lawful operations, s.61 would authorise operations without consent, or inspite of a refusal of consent, so long as the operation was for the patient's benefit and performance of the operation was reasonable.

21. M.A. Somerville Consent to Medical Care (A Study Paper prepared for Canadian Law Reform Commission, Ottawa, 1979), 44.

22. Which requires more than mere patient consent under the Contraception Sterilisation and Abortion Act 1977.

23. "...underlying the informed consent requirement is the recognition that medicine is not a purely objective, technical enterprise: determination of what is the 'right' treatment for an individual properly turns not only on the diagnosis and the risk/benefit ratios of the alternative treatments, but also on the values and needs of the individual patient." N.K. Rhoden "The Right to Refuse Psychotropic Drugs" (1980-81) 15 Harvard Civil Rights, Civil Liberties Law Review 363, 383.

24. Somerville, op.cit., 112, recommended a conceptual distinction be drawn between the traditional doctrine of consent and the more recent doctrine of informed consent, suggesting that "...the latter, being wider, will encompass the former, though the opposite proposition is not true".

25. Autonomy, expressed in the right of self determination, and inviolability are distinguishable. Autonomy allows the will of the individual to dominate, and to the extent that its expression is to protect self integrity, it accords with inviolability. The purpose of inviolability has been suggested as preserving life, health and well being, and not merely as a justification for medical treatment where the patient consents. Thus an individual's right to inviolability, it was suggested, falls "within the positive aspect of autonomy (self protection) and is limited to the extent that the negative 'anti-life-preserving' aspects of autonomy are validly exercised and take prcedence." Ibid, 5.

26. L.E. Rozovsky "Consent to Treatment" (1973) 11 Osgood Hall L.J., 103, 107, has suggested there must be five criteria for a valid consent:

    1. The consent must be voluntary.

    2. It must be knowing.

    3. It must be to the actual act performed.

    4. It must go to the particular actor.

    5. The patient must be capable of consenting.

    Plainly however many elements of informed consent there may be, they are not totally separable in all circumstances; for instance a person who lacks mental capacity to comprehend the consent being

given will also be deemed to lack sufficient knowledge on which to make an informed choice.

27. Hal shka v. University of Saskatchewan (1966) 53 DLR (2d) 436. Kelly v. Hazlett (1977) 75 DLR (3d) 536; Natanson v. Kline 350 P.2d. 1093 (1960); Speller op.cit., 19-21.

28. Somerville, op.cit., 19.

29. Chatterton supra n.8, 265; Smith v. Auckland Hospital Board [1965] N.Z.L.R., 191.

30. Kelly v. Hazlett, supra n. 27, 563 and Reibl. v. Hughes supra n. 15, 41, both recognised that a legally valid consent requires patient comprehension of the information required to be given to him by the doctor. The court in Kelly held the apparent consent of the patient to be vitiated specifically because the patient did not understand the risks, and the doctor knew that. In Reibl's case, the court holding the doctor liable in battery (and negligence) stated: "a physician [has] a strict duty to explain to his patient, in language which the patient can understand, the essential nature and quality of the treatment he is to undergo." Comprehension requires understanding not of the technical details of treatment, but rather of its possible medical and social consequences. The Canadian Supreme Court has recently overturned the decision in Reibl, and specifically disapproved Kelly. That decision is discussed later in Part I.

31. Woods v. Brumlop 377 P.2d 520, 525, (1962); Natanson v. Kline, supra n. 27. Kenny v. Lockwood (1932) 1 DLR 507, 525; Bolam v. Friern Hospital Management Committee [1957] 1 WLR 582.

32. "Competency" and "capacity" have been used inter-changeably for many years. Although competency has been considered by some as more of a legal term with capacity relating to certain mental functions recognised in medicine, the terms are basically synonymous, describing an individual's ability to understand the nature and consequences of a particular function or matter under consideration. Plainly neither should be viewed in a vacuum, but should be considered in relation to specific tasks.

33. Guardianship Act 1968, s.25.

34. Subsection 1. A child means any person under the age of twenty years - s.2.

35. Section 25A.

36. In Johnston v. Wellesley Hospital (1971) 17 DLR 3d 139, 144 the court stated that the common law does not fix any age below which minors are automatically incapable of consenting to medical procedure. It all depends on whether the minor can understand what is involved in the procedure in question.

37. P.R. Skegg "Consent to Medical Procedures on Minors" (1973) 36 MLR 370.

38. Examples of its application in the United States: Bach v. Long Island Hospital 49 Misc. 2d 207 (1966); Lacey v. Laird 166 Ohio St. 12, 39; N.E. 2d 25 (1956); Gulf & SIR Co v. Sullivan 119 So 502 (1928).

39. loc. cit., 377.

40. Ibid, 380.

41. Op cit., 75.

42. That is, situations where treatment is necessary to save life, to prevent dangerous and violent behaviour or the imminent deterioration of the patient's condition or to alleviate severe pain or distress. The rationale of the emergency exception is to permit deviation from the consent rule only in the most compelling situations.

43. Emergency treatment has been seen as both an apparent and a real exception to the consent rule. Fried Medical Experimentation - Personal Integrity and Social Policy (North Holland Publishing Co., Amsterdam, 1974), 21 argues that consent may be implied in an emergency situation where a patient is factually unable to consent. P.D. Skegg "A Justification for Medical Procedures Performed Without Consent" (1974) 90 LQR 512, 513-514 on the other hand, views implied consent as artificial, and suggests instead that emergency treatment should be justified on a doctrine of necessity. Sharpe and Sawyer Doctors and the Law (Butterworths, Canada, 1978), 21-22 have similar difficulties with implied consents, and advise that "physicians would be well advised to rely on the implied consent concept as little as possible." In preference they adopt a notion of "privilege"; that in emergencies, "...physicians are granted a privilege to do what they deem appropriate in the circumstances, without fear of legal repercussions, so long as their actions accord with sound medical practice and the patient has not refused treatment." Prosser The Law of Torts (4 ed; West Publishing Co, St Paul, 1971) 103, similarly adopts the privilege concept: Rejecting any notion of implied consent, Prosser states "it is probably more accurate... to say that the defendant is privileged because he is reasonably entitled to assume that, if the patient were competent and understood the situation, he would consent, and therefore to act as if it had been given." The authors of Salmond on Torts op.cit, 464, 467, noting the courts' dislike of the necessity defence, accept necessity where an emergency arises in the course of medical or surgical treatment for which consent has already been obtained, and where further treatment is generally of the same character. Concerning emergency treatment in the first instance, they state that "In an emergency...the law should in principle allow the defence of necessity or implied consent to an action for battery brought by an ungrateful patient, but there are difficulties in each of these defences." This does little to clarify the confusion.

Realistically it must be acknowledged that in practice it makes little difference whether emergency treatment is justified on implied consent or necessity grounds; either way the doctor is

protected. It is also worth noting that the subsequent consent of a patient to emergency treatment is not an informed consent. Rather it is a waiver of litigation rights which he may have, or a ratification of the doctor's act. Thus post hoc consent may serve as an alternative legal justification to the defences of necessity or implied consent.

44. Ibid, 523-528.

45. This is discussed in Part VI.

46. Kenny supra n. 31. The question of informed consent can arise both in battery and negligence cases. As Morden J. pointed out in Kelly supra n. 27, 555 "with respect to the former, a lack of proper information communicated by the doctor to the patient can vitiate an apparent consent, while with respect to the latter, a failure to see to it that the patient is properly advised can amount, in certain circumstances, to an act of negligence." The distinction is a difficult one.

In negligence terms, a failure to properly inform the patient raises Hedley Byrne & Co. Ltd v. Heller & Partners Ltd [1964] AC 465. Whether a narrow or broad view of the "special relationship" is adopted (see Salmond on Torts op. cit, 194) clearly the fiduciary doctor-patient relationship is included. The patient is an identifiable plaintiff, trusting the doctor to exercise a reasonable degree of care in explaining the nature and risks of treatment, and the doctor knows, or ought to know, that the patient is relying on him. A doctor who gives a misleading answer in response to a patient's inquiry about a serious problem is liable. Smith v. Auckland Hospital Board supra n. 29.

47. Male v. Hopmans (1966) 54 DLR (2d) 592; (1967) 64 DLR (2d) 105 on appeal.

48. Boase v. Paul (1931) 1 DLR 562.

49. Supra n. 27. Although the cases themselves reflected no consistency in approach: Koehler v. Cook (1976) 65 DLR (3d) 766; battery; Kelly v. Hazlett supra n.27; negligence; Reibl v. Hughes supra n. 15; battery and negligence.

50. Supra n. 8.

51. (1981) 114 DLR (3d) 1

52. Ibid, 10.

53. Ibid, 11.

54. Chatterton, supra n. 8, 265.

55. Freid op cit, 14-18.

56. One commentator; focusing on the following observation in Chatterton (supra n.8, 265):

> [i]t would be very much against the interests of justice if actions which are really based on a failure by the doctor to perform his duty

adequately to inform were pleaded in trespass.

has suggested that the English courts will inhibit the use of trespass claims in informed consent litigation, and attempt to restrict the informed consent doctrine by holding that a doctor's failure to inform gives rise to a negligence, and not tort, action.

See G. Robertson "Informed Consent to Medical Treatment" (1981) 97 Q.R. 102, 123.

57. This phrase, shortly termed "medical misadventure" has been defined as when:

(a) a person suffers bodily or mental injury or damage in the course of, or as part of the administering to that person of medical aid, care or attention; and

(b) such injury or damage is caused by mischance or accident, unexpected and undesigned, in the nature of medical error or medical mishap.
Review Decision No. 77/R 1352 p.7. The definition is further expanded in pp. 7-11.

In other words to constitute medical misadventure the side effects or materialised risks of medical treatment must be rare, completely unexpected and grave. This standard will be determined by the state of medical knowledge and opinion, rather than by reference to the patient's knowledge.

58. Accident Compensation Act 1972, s.5(1). It prohibits the remedy rather than the cause of action - Donselaar v. Donselaar (1982) Unreported judgment, Wellington Registry C.A. 145/77.

59. Donselaar; ibid, 5-6

60. See Review Decision No. 75/R1017, p.2.
In Tieljens v. Rutherford (1977) unreported judgements. Wellington Registry A 415/76, two allegations of negligence relevant to the consent issue, viz. (i) failing to warn the plaintiff that the tubal diathermy operation might not achieve the desired purpose, and (ii) failing to explain the risk of pregnancy notwithstanding the operation; were held not to amount to personal injury by accident, and did give rise to a common law claim for damages.

61. Donselaar, supra n. 58, 4. The Accident Compensation Act provides compensation for loss resulting from personal injury by accident. The torts of assault and battery are actionable without proof of loss or damage; rather they are the result of unwanted and intentional contracts, or an apprehension of contact with the person.

62. Although no doubt legally (at least at common law) and morally correct, this proposition is perhaps factually unrealistic, since the current emphasis on consent has been to equalise the doctor-patient relationship.

63. R. Plotkin "Limiting the Therapeutic Orgy: Mental Patients'

Right to Refuse Treatment" (1977) 72 Northwestern U.L.R., 461, 485.

64. Whether disclosure of treatment risks should depend upon the mental health professional's own usual customary methods and conduct, or their materiality to the patient is currently a polemic question. As noted in Part I, the latter is the preferrable standard.

65. Psychosurgery and ECT have been suggested as experimental treatments. B.A. Barnhart, M.L. Pinkerton, R.T. Roth "Informed Consent to Organic Behaviour Control" (1977) 17 Santa Clara LR 39, 56. The authors define as "experimental" treatments where there has not been sufficient research, or where research has shown that the possible benefits of treatment do not suficiently outweigh the risks, or where the research results are too inconclusive to estimate treatment outcome within reasonable limits.

66. A three tiered privilege system operates at Porirua; patient may be privileged, semi-privileged or non-privileged. Penal detention operates on the same basis. Psychiatric treatment presents perhaps the only situation where the threat of a lesser status hangs over patients refusing treatment.

67. Kaimowitz & Doe v. Department of Mental Health (1973) 42 USLW 2063. The court held that no institutionalised patient was capable of giving an informed consent to treatment. Thus non-consensual treatment is prevented, not as a result of the patient's own decision, but rather as a consequence of status (institutionalised). In the writer's opinion, Kaimowitz over-exaggerates the effects of institutionalisation, and may operate to deprive patients of treatment by denying capacity to make treatment decisions. To the extent that institutions are potentially coercive, the best defence against such coercion is likely to be an increase, not a decrease of the opportunities given to patients for individual choice and self determination.

68. Supra n.32.

69. Elimination of competency as a requisite element of informed consent to, or more pertinently, refusal of some forms of psychiatric treatment has been advocated.

> The addition of the competency element gives authorities the power, based upon personal opinions, regarding the advisability of the decision or medical diagnosis concerning 'mental illness' to negate a voluntary and knowledgeable decision...[I]t is proposed that the individual's judgment is precisely what should be sacrosanct (provided the decision involved is based on adequate, information and is voluntary). The element of 'competency' thus constitutes at best an unnecessary and perhaps an invidious component of any consent standard which might be employed in such cases." (emphasis in text) Barnhart, Pinkerton & Roth loc. cit, 72.

70. L.O.Gostin "Psychosurgery: A Hazardous and Unestablished Treatment? A Case for the Importation of American Legal Safeguards to Great Britain" (1982) JSWL 83, 91.

71. Loc. cit, 488.

72. Lunatics Act 1866, s.2.

73. Mental Defectives Act 1911, s.2.These represent four ot of the seven classes of "mentally defective persons".

74. Section 22 of the Act.

75. The one-sided nature of the evidence is readily apparent; no right is accorded to the patient, the subject of the examination, to participate in the determination of his status.

76. See for example: N. Dolan "Madness and the Law" (1973-75) 7 V.U.W.L.R. 373, 379-80; Robitscher The Powers of Psychiatry (Houghton Mifflin, Boston, 1980) 20. This is plain enough in practice, since the only expert evidence heard by the judge comes from the certificates of two medical practitioners likely supporting committal for mental disorder. The comment was made by the current superintendent at Porirua, Dr. Hall, that he has never known a judge to go against medical advice on this matter. If in any doubt, judges tend to order a s.23 adjournment (admission for observation). Lecture given to Wellington Clinical School of Medicine 5 August 1982. This is not to suggest that this necessarily leads to injustice; however one of the difficulties is that psychiatry is an imprecise science within which there appears to be considerable scope for subjective evaluation and conflicting viewpoints.

77. See for example s. 84(2) of the Act, which indicates that a protected patient may be competent to understand and make business decisions.

78. Annas "Refusing Medication in Mental Hospitals" (1980) 10 Hastings Centre Reports 33. Cited in Rhoden, loc. cit, 387.

79. Roth, Meisel and Lidz "Tests of Competency to Consent to Treatment" (1977) 134 American Journal of Psychiatry 279. The authors there concluded that in practice the test actually applied combined elements of all these tests.

80. Ibid, 283.

81. In comparison to the United States' judiciary, who are developing constitutional grounds of privacy, freedom of thought, due process and prohibition against cruel and unusual punishment, to regulate psychiatric treatment.

82. J. Jacob "The Right of the Mental Health Patient to his Psychosis" (1976) 39 MLR 17, 40.

83. A Wellington Hospital Board edict.

84. Sections 7 and 32(1)(a) respectively. Section 61A(2) Crimes Act 1961 specifically addresses the question of consent for sterilisation.

85. A recent United Kingdom study has found that over 50 per cent of patients in a London hospital were ignorant of the nature of their operation and the reasons for it, despite having consented to that treatment. Dunkelman "Patients' Knowledge of their Condition and Treatment" (1979) British Medical Journal 311

86. Loc cit. 107.

87. G. Thurston "Problems of Consent" (1966) British Medical Journal 1405

88. This would involve a deletion and substitution along the following lines:

> ...I agree to whatever treatment or operation upon
> ~~myself~~
> that may be considered necessary by the Medical or Surgical Staff....

89. Interview with Dr. Hay, Medical Superintendent Wellington Hospital, 22 July, 1982.

90. Extensive consent to treatment forms have been developed in the United States to regulate the treatment of psychiatric patients. (see appendix) Any development of consent forms along these lines however is unnecessary and undesirable. Multi-page consent forms for every medical procedure have been rejected by some United States courts, as no reasonable patient could be expected to understand and assimilate them. Clear and succinct consent forms, answering the earlier criticisms, should be possible.

Treatment contracts exist as an alternative. Many consent forms probably already contain elements of contract, such as the payment of fees, and the doctor-patient relationship is frequently referred to as a contractual one. Essentially consent authorises touching, and prevents the tort actions of assault and battery, while contract embodies mutual agreements and expectations. Plainly a treatment contract would embody a consent agreement.

Despite the suggested benefits of a treatment contract; for example the mutual negotiation of treatment goals, encouraging a more open discussion of privileges and responsibilities involved within the hospital and; where the patient is a minor or incompetent, the addition of a third party to protect their rights, in the writer's opinion they would be of diminished value for psychiatric patients, whose contractual rights and capacity may be less well defined in the treatment area. Similarly suggestions of coercion, undue influence and unconscionability may limit the efficacy and validity of a contract.

See Schwitgebel Legal Aspects of the Enforced Treatment of Offenders (National Institute for Mental Health, Centre for Studies of Crime and Delinquency, Rockville, 1979), 49-60.

91. Sharpe and Sawyer op. cit, 49.

92. Chatterton supra n.8, 267. But cf a legislative recent development in the United States, infra n.162.

93. Under s.7 of the Act, the management of mental health institutions (barring Lake Alice Hospital in Marton which makes national provision for security patients and is administered by the Health Department) is placed under the jurisdiction of their respective hospital boards. Admission and consent to treatment in psychiatric hospitals are thus regulated by the boards.

Porirua Hospital, which provides the factual basis for this paper, is administered by the Wellington Hospital Board.

94. Whether in fact informal admissions reflect truly voluntary patients is questionable. Voluntary admission may reflect merely the failure to protest hospitalisation, or familial or official coercion; certainly the belief that admission as a committed patient follows any refusal of treatment is often well founded. The Porirua Ward Manual provides that "very occasionally it is necessary to consider the committal of an informal patient for example if an informal patient is adamantly refusing treatment which appears to be urgently needed for the safety of themselves or others." However, "in most cases an informal patient will be allowed to discharge himself if he so wishes, and steps to commit such a patient will only be taken after very serious consideration." C.1.

For minors, the volition of admission is even more dubious. Without question it is in the nature of parenthood that parents have the legal right and duty to care, provide and make decisions for their children. However, under these auspices it is all too easy for a difficult, misbehaving child to be admitted more for the benefit of the family, rather than the child's therapeutic benefit. Certainly the child's opinion that admission is unnecessary or not in his best interests is unlikely to decide the question.

95. Hereinafter referred to as the Act.

96. Sections 15(1)(a) and (b) respectively.

97. This consent requirement, implicit in s 15(2) of the Act, is explicit in s 25(3) Guardianship Act 1968.

98. Apart from hospital administration, the main purpose of admission forms is to provide data on the mental health system for the National Health Statistics Centre.

99. Interview with Mrs. Cosgrove, Patient Affairs Supervisor Porirua Hospital, 22 July 1982.

100. Section 28(1) provides that every reception order shall continue in force until the patient is discharged.

101. Generally three to five sessions, depending on how depressed the patient is; supra n. 99.

102. Idem.

103. Section 44(5)

104. For example, persons acquitted on grounds of insanity.

105. Supra n. 89.

106. Supra n. 99.

107. Interview with Mrs. McDonald, Administration Officer Hillview 22 July 1982.

108. Idem.

109. Sometimes Hillview clients are committed to Porirua if very seriously disturbed. Committal proceedings obviously will be without consent.

110. The Code, written in eight languages other than English, is drafted in simple, clear and understandable terms, with a commendable absence of medical and legal jargon.

111. By this, has the hospital therefore recognised the invalidity of patient consent obtained at admission?

112. Telephone interview with Dr. Hay, Medical Superintendent, Wellington Hospital 15 September 1982. As an example, Dr Hay cited Accident and Emergency patients, with head injuries or concussion, who frequently discharge themselves against medical advice.

113. Idem.

114. Supra n. 99. This is also stated in Porirua's own right pamphlet.

115. Lunatics Act 1866, s.3.

116. Defined in s.3 as "any person idiot, lunatic or of unsound mind and incapable of managing himself or his affairs...."

117. See for example, s.6(2)and (6), dealing with the removal of lunatic prisoners from prison to an asylum or hospital, where necessary for curative treatment; s.19 requiring that a Resident Magistrate when committing, be satisfied that the committed person is a proper person to be detained under care and treatment; s.57, the asylum Casebook required to record, for each patient, "a correct description of the medicine and other remedies prescribed for the treatment of his disorder"; and schedule numbers 2and4.

118. Mental Defectives Act 1911, s.2.

119. Section 19 (1).

120. Section 19 (3).

121. Dr. Hall, Medical Superintendent at Porirua, supra n. 76.

122. Either the judge himself is not satisfied that the patient is mentally disordered; or the medical practitioners believe the patient "may be mentally disordered and that his mental condition should be under observation for the purpose of ascertaining whether he is mentally disordered" s.23(1)(a)and(b) respectively.

123. Section 23(2).

124. Sections 23 (2) and (3) respectively. Where admitted under this section for observation, the patient can only be detained and treated for an aggregate of two months cf in the United Kingdom, detention for observation is only for 28 days. Mental Health Act 1959 (U.K.) s.25(4).

125. Section 28(1).

126. Section 55(2) The review is conducted by the medical superintendent.

127. Sections 16 and 24 respectively.

128. Section 25(1).

129. Section 19(6).

130. Section 23(8).

131. Section 2. This does not apply to the third class of mental disorder - mental subnormality.

132. Concise Oxford Dictionary. (6th ed. Claredndon Press, Oxford, 1976), 954.

133. The very existence of a psychiatric hospital should mean no more than the availability of psychiatric care and treatment.

134. Section 2.

135. "Psychiatric Points of View Regarding Laws and Procedures Governing Medical Treatment of the Mentally Ill" (Special Information Bulletin No. 1 September 1962). Joint information service of American Psychiatric Association and National Association for Mental Health. Cited in Szasz The Age of Madness (Routledge & Kegan Paul, London, 1975) 232

136. Section 24(1) "If...the [District Court Judge] is satisfied that the person is mentally disordered and requires detention in a hospital either for his own good or in the public interest...."

As justifications for the restraint of psychiatric patients, these two grounds have a long history, dating as far back as medieval times. P. Noble "Mental Health Services and Legislation - An Historical Review" (1981) 21 Med. Sci. Law 16.

137. Being. "Mentally disordered" under s.2.

138. The vague criteria of dangerousness should be clarified prior to prediction. Without prior agreement about what behaviour constitutes a dangerous act, considerable disagreement and low predictive accuracy are likely. Miller and Fiddleman (loc.cit., 991) provide extensive references to studies indicating the questionable validity of psychiatrists' predictions of patient dangerousness. Increasingly overseas, provisions are requiring evidence of specific acts, attempts or threats of physical harm before committment.

139. A restricted definition of "for his own protection" was proposed, limited to either where the person has attempted to kill himself or cause himself serious bodily harm; or where there are reasonable grounds for belief in the likelihood that the person will, by act or neglect, cause death or serious bodily harm to himself. As far as can be ascertained, no action has followed these proposals; certainly the New South Wales Mental Health Act remains unchanged. " Proposed Amendments to N.S.W. Mental Health Act 1958 ". Report of Mental Health Act Review Committee 1975.

140. See for example: Mental Health Act RSO 1970 (Ontario) s. 8(1)
Mental Health Act SBC 1964 (B.C.) s. 23(1)
Mental Health Act RS5 1965 (Sask.) S.11
Mental Health Act 1976-77 (S.Aust) S.14(1)
Mental Health Act 1959 (U.K.) s.26(2)(b).

141. Hon. Mr. L. Gander, M.P. during the third reading of the Bill stated: "I welcome the Bill because of this emphasis away from the quite artificial distinction between psychiatric and physical medicine...." New Zealand Parliamentary Debates 360, 435 30 May, 1969.
Post-1969 practice has reflected the continued segregation of physical and mental illness.

142. Discussed more fully in Part 1.

143. Discussed in Part II.

144. Explicitly the Act makes no reference to in/competency. Incompetency, both to manage property and make treatment decisions is apparent for committed patients. Under Part VII, the Public Trustee in managing and administering the estates of protected persons (defined in s.82 and basically covering committed patients) shall, so far as is practicable and expedient, consult the patient and may act on that advice (s. 86(2)). the concurrence or otherwise of the patient is of no concern to the person dealing with the Public Trustee (s. 86(4)). Discharge coupled with evidence of the patient's ability to manage his own affairs will terminate the functions of the Public Trustee (s.86(5)(b). Incompetency is presumed by admission (s.85) and may be rebutted upon discharge. Incompetency to make treatment decisions is also evident. Committal precludes the need to obtain either patient consent or that of a relative or guardian, s.25 providing that a reception order "shall be a sufficient authority" for the superintendent who "may give [the patient] care and treatment". Similarly s.19(6) certification provides that the superintendent "may give the patient care and treatment". Incompetency thus has statutory recognition, albeit implicit.

145. This comment applies equally to informal patients who, upon admission, sign a standard consent form which purports to operate as a blanket consent to all future treatment. (The efficacy of the consent is considered in Part III).

146. Loc. cit., 93.

147. See the title: "An Act to consolidate and amend the Mental Health Act 1911, and to make further provision for the care and treatment of mentally disordered persons."

148. Gostin, commenting in the United Kingdom context but in the writer's opinion, equally applicable to New Zealand, remarked that "...delegating unfettered discretion to the medical profession and relying on the existence of 'good practice' has been shown historically to be an ill-conceived policy which has worked to the detriment of psychiatric patients". Loc. cit, 89.

149. Jacobs, loc. cit, 23-24.

150. Defined in s. 26(2)(a) as:

(i) In the case of a patient of any age, mental illness or severe subnormality;

(ii) In the case of a patient under the age of 21 years, psychopathic disorder or subnormality.

"Mental illness" is not defined in the Act. Its meaning was considered in W v. L [1973] 3 All ER 884, 890 Lawton J. commenting that "the words are ordinary words of the English language. They have no particular legal significance. How should the court construe them? The answer in my judgment is to be found in the advice which Lord Reid recently gave...namely that the ordinary words should be construed in the way that ordinary sensible people would construe them."

151. Section 147(1).

152. Section 26.

153. Section 25.

154. Section 31(2).

155. The interpretation of the Department of Health and Social Services as outlined in the 1975 Butler Report, was that since couched in terms of a mental disorder of such nature and degree to "warrant" detention for medical treatment, then one purpose of the detention must be to enable the patient to receive any recognised form of treatment for the mental disorder from which he is suffering. Consequently, such treatment as is considered necessary may be administered, irrespective of the patient's wishes.
United Kingdom Report of the Committee on Mentally Abnormal Offenders, (1975 Cmnd 6244) Para.3.57.

This has since been confirmed both by the 1978 Review of the Mental Health Act 1959 (1978 Cmnd 7320), and more recently, the Department Under-Secretary for Health and Social Security : "The Department's view is that the Mental Health Act gives implicit authority to administer recognised forms of treatment for mental disorder, without the patient's consent where necessary." Great Britain House of Commons debates, (1979-80), 985, 1980, 824.

156. Butler Committee, ibid paras 350-356.

157. Mental Health Act 1958-65 (N.S.W.) s. 109A(5).

158. Section 4.

159. Mental Health Act 1959 (Vic.) s. 102(3).

160. Section 102(4).

161. Mental Health Act 1976-77 (S.Aust.) s.5.

162. The United States is typically regarded as a frontrunner in the field of mental health reform. Although present trends still concentrate on reducing involuntary hospitalisation, "...a more recent upsurge in interest in 'law and order', and the protection of society has led to a retrenchment of the move towards greater rights for mental health patients, and to increased pressure from members of the public to protect them from exposure to mental health patients as well as from criminals." Miller and Fiddleman loc. cit, 1018. Furthermore, there has been a developing tendency for individual states to enact legislation which severely restricts the operation of informed consent. Some, for example, go so far as to create a presumption, rebuttable only on proof of fraud, that a patient's signature is conclusive evidence of informed consent having been given. Robertson, loc.cit, 108.

163. For example: N.Y. City Health and Hospitals Corp v. Stein 335 NYS 2d 461;(1972) Dale v. Hahn 440 F 2d 633 (1971); Rogers v. Okin 478 F. supp. 1342 (1979);Winters v. Miller 466 F 2d 65 (1971); 404 US 985 (1972).

164. For example: M.A. Stone "The Right of the Psychiatric Patient to Refuse Treatment" (1976) 4 Journal of Psychiatry and Law 515; Plotkin, loc.cit; Rhoden loc.cit.

165. The principle that a person should not be deemed incompetent to consent solely because he is hospitalised or receiving psychiatric treatment has been codified in several states. For example: Cal. Welf. and Inst. Code 5331 (West Supp. 1976);Mass.Ann. Laws Ch. 123 § 25 (1972).

166. For example: Stowers v. Wolodzko 191 N. W. 2d 355 (1971); Scott v. Plante 532 F 2d 939 (1976); Rogers v. Okin supra n. 163.

167. World Health Organisation Expert Committee on Mental Health Fourth Report "Legislation Affecting Psychiatric Treatment" 1955 para. 3.4.

168. The Royal Commission of the Law Relating to Mental Illness and Mental Deficiency (1957 (Cmnd 169) para 3.16.

169. Devlin op.cit., 92.
A concept of privilege has been suggested by some commentators as more appropriate a justification for emergency treatment. This is discussed more fully earlier in the paper; supra n. 43.

170. Position statement on the Question of Adequacy of Treatment (1967) 123 Am. J. Psychiatry 1458, 1459.

171. Barnhart, Pinkerton and Roth, loc. cit., 69-70, reject any notion of substitute consent for incompetent patients. "It is our position that no organic procedures should be administered unless there is the positive informed consent of the person who is to be subjected to the procedures, and that competency as traditionally conceived should not be an element in the evaluation of such a consent. The only exception should be emergency cases where there is a dear and imminent danger of immediate fatality unless the procedure in question is performed, and no less drastic measures could avert that fatality."

172. The potential conflict where a doctor's clinical judgment collides with that of the patient is readily apparent. In resolving that conflict, the law must take account of more than a physician's sincerity, diligence and professional competence; but also the wishes and legal rights of a competent patient.

173. Rhoden loc.cit., 402.

174. Consent rules for minors have been suggested that limit the treatment of minors to therapeutically beneficial interventions, or at most, to minimal risk ones. In the writer's opinion there is no justifiable or logical reason for applying a different rule to the treatment of incompetent psychiatric patients, who are very much in the same treatment position as minors.

175. Op.cit.,86.

176. In this respect the 1977 Commission of Inquiry's findings concerning the treatment of a Niuean boy at Lake Alice Hospital (supra n. 93) provide considerable cause for alarm. On several occasions, in the normal course of his treatment, the thirteen year old boy received unmodified and unauthorised ECT treatment. It was not an emergency measure. The boy was a minor and legally, his treatment required express parental consent. Express consent was not even provided by the treatment staff. Despite this, the Commission readily concluded that "authority for his treatment can be implied from the conduct of the people concerned..." (p.23). Furthermore, the Commission accepted an absence of any consent forms regulating treatment: "Lake Alice Hospital does not use written consent forms, on the basis that people will often say later that they did not understand what they signed." (p.11). This is disturbing, particularly considering the practice of other psychiatric hospitals who seek specific consent for ECT.

Report of the Commission of Inquiry into The Case of a Niuean Boy. 18 March 1977.

177. Porirua ward manual A. 5(g).

178. Ibid A.25 (3)(a).

179. In Ontario for example, the attending physician, one of the hospital's psychiatrists and an outside psychiatrist each certify that they have examined the patient and are of the opinion that the patient's mental condition is likely to be substantially improved by a specific treatment, and unlikely to improve without it, before making an application to an independent regional

board. s.31(a)(4) Mental Health Act 1970.

180. See "Declarationsof Helsinki. Recommendations guiding medical doctors in biomedical research involving human subjects." At I Basis Principles, para.10 which suggests that an independent physician may obtain consent.
Adopted by the 18th World Medical Assembly, Helsinki, Finland 1969. As revised by the 29th World Medical Assembly, Tokyo, Japan 1975.

181. See Part VII of the Act.

182. Sections 5, 56-65.

183. As opposed to guardianship over a patient's property and financial affairs, which is already catered for by Part VII of the Act.

184. For example s.3 Guardianship Act 1968 dealing with parental guardianship.

185. Mental Health Act 1959 (U.K.) s. 33(1). Excluded therefore are persons suffering from a minor disorder - subnormality or psychopathy, for whom it has been suggested the Court of Protection might provide a means of obtaining consent for these patients. Jacobs loc.cit.,38.

186. Mental Health (Hospital and Guardianship) Regulations 1960 (U.K.) reg.6.

187. Section 34(1).

188. Discussed in Part II.

189. Mental Health Act 1976-77 (S.Aust.) Part IV.

190. s. 26(1) A "mentally ill" person must be either "incapable of looking after his own health and safety" or be "incapable of managing his own affairs". A person suffering from mental handicap either must be "incapable of managing his own affairs" or "requir[ing] oversight, care or control in the interests of his own health and safety or for the protection of others".

191. Sections 27(1)(b) and (d) respectively.

192. Section 27(4).

193. The unnecessary addition of further institutional structures should be avoided, both from the point of view of a duality of bureaucracy, and ever-present cost considerations.

194. Defined in s. 82 of the Act, and essentially covering committed patients.

195. The Butler Report, loc.cit, para. 2.45. Obviously, this is in relation to mentally abnormal offenders; however, in the writer's opinion, the point is equally valid for any patient being considered for guardianship.

196. Ibid, para. 15.4.

197. At least in theory. Whether in practice Board membership is predominantly non-medical depends upon the background of the "appropriate" persons.

198. See McLauchlin Guardianship of the Person (National Institute on Mental Retardation, Downsview, Ontario, 1979) 60-70 where the author examines the operation of Alberta's Public Guardian, an independent public agency.

199. Guardianship for Mentally Retarded Adults: Submissions to the Minister of Justice, (New Zealand Institute of Mental Retardation, Wellington, 1982).

200. Ibid, 31.

201. Incompetency, as noted earlier, need not be all embracing; for example a patient found incompetent to manage his property and business affairs may yet be competent to consent to treatment.

202. Title to the Act.

203. Section 124(2).

204. Prior to 1935, the precursor of s.124 protected persons from liability if they had acted in good faith and with reasonable care. In the 1935 Mental Defectives Amendment Act, s.6 turned the onus of proof around, and required the plaintiff to show either bad faith or the lack of reasonable care.

205. Psychiatric treatment and patient care at Oakley Psychiatric Hospital is currently under scrutiny by a Commission of Inquiry, and the subject of widespread public debate, following the recent death of an Oakley patient from ECT treatment.

206. Gostin, loc.cit, 89.

207. Richardson v. LCC [1957] 2 All ER 330,339 per. Parker L.J. Although "...there are limits to which the plaintiffs can be expected to prove a negative. They cannot give evidence about what was in the defendant's mind." Buxton v. Jayne [1960] 1 WLR 783, 793, per Devlin, L.J.

208. Pountney v. Griffiths [1975] 3 WLR 140, 141 per Lord Simon of Glaisdale.

209. Robertson, loc.cit/56 pointed to five factors that suggested judicial policy in England would not develop the notion of informed consent.

    1. Current judical policy, as evidenced in the House of Lords decision in Whitehouse v. Jordan [1981] 1 All ER 267, against expanding the liability of the medical profession.

    2. A fear that acceptance and development of the doctrine of informed consent might lead to the practice of defensive medicine.

    3. The fact that the doctor's duty to disclose 'real' risks inherent in a proposed treatment is seen merely as one part of his overall duty of care.

4. Expert evidence as to accepted medical practice is likely to exert a considerable influence over the scope of the doctrine.

5. Strict application of the causation requirement is likely to create serious difficulties of proof for plaintiffs in informed consent litigation.

210. Any consent legislation, in the writer's opinion, should use the language of choice, rather than rights.

There has been extensive acceptance in the United States, of both a right to treatment and a right to refuse treatment, mainly on constitutional grounds. The notion of rights may also be seen as an ethical obligation of society to provide adequate and effective services for all mentally disordered persons needing them (the rationale being that society may ultimately be measured, in a moral sense, from the way it treats its most vulnerable and disadvantaged members). To some extent this is an extension of the existing ethical foundation of our present mental health system.

However, the point is, of course, that treatment and care expected to benefit the patient are made available at psychiatric hospitals. Treatment, it has been suggested, should not proceed without consent - patients determining the extent of intervention by choosing either to accept or reject the available treatments. Assenting to, and refusing treatment are better seen as a choice, than a right. Thus references to the "normal right of patients to receive care and treatment" in Porirua's ward manual (A.23), and the rights to consent to, and refuse treatment in the patients' Code of Rights should be read in this light.

211. Supra n. 141.

212. By comparison, many overseas provisions are couched in terms of a prohibitory rule along the lines of: "No treatment shall be administered without consent..." Within a positive expression of the consent requirement, Somerville op.cit, 36 suggested that a distinction in underlying attitude existed between the statement that a patient consents to treatment, and a patient consents to waive a right against treatment. The former, she suggested, gave the impression of having consented to a particular treatment once and for all, and that subsequent withdrawl depended upon a separate right of revocation; whereas the latter emphasised the need for a continuing consent, since revocation is only waived while the consent continues. The practical result however is the same for both. Given this, the former statement is to be preferred as a simple and clearer definition of the consent requirement.

213. This provision is modelled on s.19 Mental Health Act 1976-77 (S.Aust.), which presently restricts only the administration of psychosurgery and ECT.

214. Similarly, this definition is based on s.5.

215. Currently in practice this is how general hospital and informal psychiatric patient consent is obtained, except for ECT treatment.

216. Mental Health Act 1959 (U.K.) s. 147(1).

217. P. McNamara "Psychophamacotherapy in South Australia" (1980-81) 7 Adelaide L.R. 323, 343.

218. See for example: s.19 Mental Health Act 1976-77 (S.Aust.); ss.108, 109 Mental Health Act 1958-60 (N.S.W.); Mental Health (Amendment) Bill 1982 (U.K.) (cited in Gostin, loc.cit.,93). Legislation in some cases provides such liberal exceptions that in practice the right is rendered worthless. For example, Georgia's legislation limits the need for consent to procedures that are not considered 'standard psychiatric treatments' (which the statute does not define). (Ga. Code. Ann § 88-502 3(a) 19 71). In Massachusetts, patients can refuse psychosurgery or ECT but the hospital can override the excuse for good cause. (Mass. Gen. Laws Ann. Ch. 123 § 23 (West. Supp. 1977).

219. Dr. Hall, supra n. 76.

220. The current polemic focusing on ECT treatment is not limited, but is rather the manifestation of a persuasive concern about the whole practice of psychiatric treatment.

221. From s.9 Mental Health Act 1976-77 (S.Aust).

222. Discussed in Part IV.

223. Hon. Mr. L. Gandar New Zealand Parliamentary Debates, 360, 435, 30 May, 1969.

224. Hon. Mr. A. Highet, ibid, 436.

225. See s. 24(1) of the Act.

226. Trilling, op.cit.

227. Lunatics Act 1866,s.3.

228. Under the present Act.

APPENDIX A. Wellington Hospital
Current Consent

WELLINGTON HOSPITAL ADMISSION FORM

Surname Mr.
Mrs.
Miss

Marital Status

Hospital Number

Other Names

Religion (Reply optional)

Admission Date

Admission Time

Usual Residential Address in N.Z.

Home Phone of Patient

Ward

Birthplace

Birthdate

Consultants

Age

Sex

Maori
Pacific Islander
Other

Occupation and Branch of Industry

Address from which admitted

Employer's Name

Address

Referring Doctor

Previous surname if changed

Patient's General Practitioner

Name of next-of-kin

SOCIAL SECURITY ENTITLEMENT

Address

Address

How long have you lived in N.Z.

If not usually resident in N.Z., how long are you going to stay here?

Provisional Diagnosis

Relationship

Permanent overseas address if not usually resident in N.Z.

Phone Day

Phone Night

Alternative name for messages

ACCIDENT DETAILS — Required only if admission resulted from accident.

Emergency ☐ Waiting List ☐ Booked ☐

Address

Traffic | Work | Other

Specialty

If other, what happened?

Notes to ward with patient Yes ☐ No ☐

Next-of-kin Notified Yes ☐ No ☐

Relationship

Where (Home, Office, Street, Factory)

Signature

Phone Day Night

When

FOR ADMINISTRATION OFFICE USE

State whether emergency messages to be given to next-of-kin or alternative above

I.P. Register No.

Discharge Date

CONSENT TO TREATMENT OR OPERATION: I hereby declare that the information given by me is correct and I agree to whatever treatment or operation upon

....

that may be considered necessary by the Medical or Surgical Staff AND I further agree to pay the prescribed maintenance fees on behalf of the above named or myself, if remaining in Hospital after the Medical Staff considers that hospital treatment is no longer being received.

Signature ....

Witness: ....

FOR WARD USE

Discharge Date

Discharge Time

Enquiry Office notified by

APPENDIX B. Wellington Hospital
Fut[illegible] Consent

C O N S E N T F O R M

I, ...of...
(name and address of person giving consent)

*hereby consent to undergo

*hereby consent to .... undergoing
(name of patient)

the operation/treatment of ....

the nature and effect of which have been explained to me
by Dr / Mr ....

I also consent to such further or alternative operative measures or treatment as may be found necessary during the course of the operation or treatment and to the administration of general or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation/treatment will be performed or administered by any particular practitioner.

Date: .... Signature of ....
Patient/next-of-kin/guardian*

I, husband/wife, *of the above-named patient, hereby confirm my consent to the above. ≠

Date: .... Signature of spouse ....

I confirm that I have explained the nature and effect of this operation/treatment to the person(s) who signed the above form of consent.

Date .... Signature ....
Physician/Surgeon*

*Delete whichever inapplicable.

≠ It is recommended that if the patient be married and the procedure likely to affect sexual or reproductive functions, the signature of the spouse should also, when reasonably possible, be obtained.

Consent Form

I, ______________________, hereby knowingly and vol-
(Name of person giving consent)
untarily consent to my treatment (consent to the treatment of my child/ward
______________) by the __________ and the professional staff
(child's name)
of the __________. Such consent for treatment shall include all forms of
treatment deemed necessary by the professional staff of said __________
and shall include but shall not be limited to any of the following treatments,
which are not crossed out:

Individual Psychotherapy
Group Psychotherapy
Progressive Muscular Relaxation
Hypnosis
Systematic Densensitization
Covert Sensitization
Avoidance and Escape Conditioning
Operant Conditioning Procedures
Classical Conditioning Procedures
Sensory Deprivation
____
(Other)

I further state that the above procedures have been fully explained to me and that I fully understand them.

____
(Signature)

Dated: ______________________

____
(Witness)

Adapted form: Peoria Mental Health Clinic, 1977.

Consent for Token Economy Project on Behalf of Incompetent Person

I, the undersigned, in my capacity as legal guardian, consent to have ______[Name of patient]______ included in the Token Economy Program. I understand that this program will involve earning tokens by appropriate behavior in order to pay for privileges, meals, and living accommodations. I understand visiting privileges and home leaves are encouraged; but such privileges will be dependent on the decision of the staff, based on the need and behavior of the individual patient. Leaves may be requested for one weekend per month (Friday evening to Sunday); visits for the day on Saturday or Sunday.

I am aware that this program is directed toward either return home or family care placement; and that, whenever, upon the decision of the Ward Team, it is thought that such placement is appropriate, such plans will be made.

____
(Signature of Guardian)

____
(Signature of Patient, if available)

____
(Signature of Witness)

____
(Date)

UCLA NEUROPSYCHIATRIC INSTITUTE RESEARCH PROGRAM

CAMARILLO CLINICAL RESEARCH UNIT

Consent Form—A

Program Participation

I understand that I am participating in a program that is designed to teach new skills that may allow me to deal more effectively with stressful situations, social activities, and personal relationships. My program will be a 8 to 14 day treatment period in which I will receive instruction in the techniques of desensitization, assertion training, and family contracting. Each of these techniques has been described to me in detail. I understand that while I am participating in the treatment program, I will not receive antidepressant medications or tranquilizers. I will be permitted to continue other regularly prescribed medications at the discretion of the program's physician and that I will be permitted to consult my own physician at any time. I understand that the program makes use of two distinct approaches to treatment and that I have been assigned to one of these at random. I further understand that these two different types of approaches to treatment constitute the experimental aspect of the overall treatment program. I also understand that this program is being evaluated to determine its effectiveness and that an important part of the evaluation will involve completing psychological questionnaires and personal interviews during the program and in five follow-up sessions at a community mental health center. I consent to participate in the program with the understanding that my anonymity and confidentiality will be maintained.

I understand that the program is entirely voluntary, and that I may withdraw at any time. I have had the program described to me and have been given an opportunity to ask questions and have them answered to my satisfaction.

________________ Date

________________ Signature of Patient

________________ Date

________________ Signature of Witness

APPENDIX D. Porirua Hospital Admission

ADMISS[obscured by punch hole]/READMISSION/REPLACEMENT FROM [obscured by punch hole]AVE

MENTAL HEALTH SYSTEM

N.H.S.C.
H384
Complete this form for (1) First Admission
(2) Readmission
(3) Replacement from leave (over 10 days duration)
NOTE: Where a choice is given, circle required box

SYSTEM CODE M H S
FORM CODE 3 1
N.H.S.C. use only

1. HOSPITAL ADMITTING PATIENT
(a) Name ____ (b) Code 9
(c) Ward ____ (d) Local Reg. No. ____

ADMISSION INFORMATION FOR HOSPITAL RECORDS

Do NOT complete this section if the patient is being replaced from leave.

(i) RESIDENCE
(a) Is patient ordinarily resident in New Zealand
Yes Y No N
(b) If not ordinarily resident in New Zealand what provision is made for maintenance?

(ii) WAR SERVICE ____

(iii) SOCIAL SECURITY BENEFIT
TYPE ____

(iv) S/S BENEFIT, HUSBAND/WIFE
TYPE ____

(v) DRIVER'S LICENCE Yes Y No N

(vi) NEXT OF KIN (a) Relationship ____
(b) Name ____
(c) Address ____
(d) Telephone: ____

(vii) OTHER RELATIVE OR FRIEND
(a) Relationship ____
(b) Name ____
(c) Address ____
(d) Telephone: ____

(viii) USUAL DOCTOR
(a) Name ____
(b) Address ____

(ix) RELIGION ____

(x) PREVIOUS ADMISSIONS TO THIS HOSPITAL

Admitted	Discharged

2. FAMILY NAME

3. FIRST GIVEN NAME

4. OTHER GIVEN NAMES

5. ADDRESS

6. DOMICILE CODE

7. GENERAL DESCRIPTIVE DATA
Maiden Name
Also Known As and Other Data

8. DATE OF BIRTH Day Month Year

9. AGE (on last birthday)

10. SEX Male M Female F

11. RACE Maori M Pacific Islander P Other O

12. TYPE OF ADMISSION
(a) First F
(b) Readmission R
(c) Replacement from leave (not informal patients) L
(d) Unknown U

13. DATE OF ADMISSION OR REPLACEMENT Day Month Year

14. REGISTRATION NUMBER (Supplied by N.H.S.C.)

15. ADMISSION NUMBER (Supplied by N.H.S.C.)

16. STATUS ON ADMISSION — Informal [I] Special [S] Committed [C] Remand [R]

(a) If SPECIAL patient

C.J.A. Sect. 39G (1) (a)	A	M.H. Sect. 42 (4) T.R.O.	D
C.J.A. Sect. 39G (1) (b)	B	M.H. Sect. 43	E
M.H. Sect. 42	C	C.J.A. Amendment to S.P.A. Sect. 171 (3)	F
			I

Other Sections please specify ______

(b) If COMMITTED patient

M.H. Sect. 19	J	C.J.A. Sect. 39 I	N
M.H. Sect. 21	K	C.J.A. Sect. 39G (2)	O
M.H. Sect. 23	L	C.J.A. Sect. 39J	P
M.H. Sect. 24	M	H.A. 126A (1)	Q
			R

Other Sections please specify ______

(c) If REMAND patient

C.J.A. Sect. 39B (1)	S	C.J.A. Sect. 47A (2) (c)	U
C.J.A. Sect. 39B (2)	T		

Other Sections please specify ______ [V]

17. IF PATIENT IS EITHER UNDER THE ALCOHOLISM AND DRUG ADDICTION ACT, OR CRIMINAL JUSTICE ACT, SECT. 48A

Sect. 21 ADA	A	Committed Sect. 9 ADA	C
Committed Sect. 8 ADA	B	C.J.A. Sect. 48A	D
			E

Other Sections please specify ______

18. COUNTRY OF BIRTH

(a) Country where born ______ (b) Code

19. LENGTH OF STAY IN NEW ZEALAND

(a) If New Zealand born, leave blank (b) If overseas born, enter number of years in New Zealand

20. MARITAL STATUS

(a) Single	S	(c) Separated	P	(e) Widow/er	W		
(b) Married	M	(d) Divorced	D	(f) De Facto	F	(g) Unknown	U

21. PATIENTS OCCUPATION ______ Code

22. DATE OF RECEPTION ORDER (for committed patients only) Day Month Year

23. REFERRAL SOURCE

Self and/or relatives	S R	Psychiatric Outpatients	P O
Private Psychiatrist	P P	Psychiatric Day patients	P D
Other medical practitioner	O M	Law enforcement agency	L E
Non psychiatric hospital unit	N P	Inpatient sector of psychiatric care	P I
Psychiatric unit of general hospital	P U	Other non-medical agency	O A
Geriatric Unit (not general hospital)	G U	Not stated	N K
		Domicillary Nursing Service	D N

24. DIAGNOSIS

______ ICD Code

Prepared by ______ Date / /

Checked by ______ Date / /

ADMISSION TO ANY OTHER N.Z. OR OVERSEAS PSYCHIATRIC HOSPITAL
(Including Queen Mary, Hanmer) PSYCHIATRIC UNIT OF A PUBLIC HOSPITAL

Hospital	Admitted	Discharged

PORIRUA HOSPITAL,
PORIRUA.

____
(Date)

CONSENT TO TREATMENT

I hereby agree to whatever treatment upon ____________________

that may be considered necessary by the medical staff of Porirua Hospital and in the event of my son/daughter/ State Ward being under 16 years of age and wishing to leave hospital unexpectedly, I hereby authorise his/her detention until I am notified.

Signature: ____________________

Witness: ____________________

Date: ____________________

APPENDIX F. Porirua Hospital
Consent to ECT

PORIRUA HOSPITAL

Address all communications to
The Medical Superintendent

~~Telegraphic address:~~
~~Porirua~~

Please quote reference

Private Bag,
Porirua.

Telephone Porirua 74 539

I .... of
(first names) (surname)

....
(address)

agree to a course of E.C.T. (convulsive therapy), with a general anaesthetic as needed, being administered for treatment of psychiatric disorder to:

(a) Myself.

(b) ....(Patient's name)

Where this consent is being given on behalf of a patient, rather than by the patient himself, I also state that I am either the nearest relative, or the person most appropriate to give such consent in the absence of the nearest relative.

The general nature of the procedure and its possible side effects have been explained to me.

(signed)........................

(date) ....

(Witness)........................

APPENDIX G. Wellington Hospital
Consent to ECT

WELLINGTON HOSPITAL

Address communications to
Official title appearing below:

Private Bag,
Wellington Hospital.

Please quote reference

Riddiford Street,
Newtown, Wellington 2

Telephone 855-999

CONSENT FOR TREATMENT

I, ... , of
(first names) (surname)

.... ,
(address)

agree to receiving a course of E.C.T. (electro-convulsive therapy) with a general anaesthetic, for treatment of my psychiatric disorder. The nature of the procedure and its possible side-effects have been explained to me.

(signed) ....
(date) ....
(witness) ....

Date: ....

Physical condition

Current medication

Allergies

Signed: ....

WELLINGTON · HOSPITAL

Address communications to Official title appearing below:

Private Bag,
Wellington Hospital.

Please quote reference

Riddiford Street,
Newtown, Wellington, 2.

Telephone 659-844

ABOUT E.C.T..........

What is it? Some people call it "shock treatment", but E.C.T. is correctly known as electroconvulsive therapy.

It's been used for 40 years to treat severe depression and other distressing forms of psychiatric illness.

How is it Given? With modern methods, E.C.T. is given while you are asleep under a light anaesthetic. A low-voltage electric current is passed through electrodes placed on the front of your head. This has stimulant effect on those parts of the brain concerned with emotional life.

How often? Though you may feel a little better after just one E.C.T., usually 5 or 6 treatments are necessary. These are given at intervals of 3 to 4 days.

Side-Effects? E.C.T. is no "miracle cure". It takes time to work, and it does have some side-effects such as brief headache and muscle aching immediately after each treatment. And after several treatments, you may find your memory transiently impaired so that it's hard to remember details of recent events.

Limitations? Moreover, E.C.T. relieves depression and certain other symptoms, but it can't alter outside influences and family problems which may be worrying you. It can help you only by getting you well enough to tackle those kind of troubles in other ways.

Safety? For specific depressive and other conditions diagnosed by your psychiatrist, E.C.T. is both safe and effective. It won't produce any lasting ill-effects, and it's neither painful nor frightening. It has helped many thousands of patients on the road back to normal health.

To ensure you get the maximum benefit when E.C.T. has been prescribed, follow these DO'S and DONT'S:

1. DON'T eat or drink anything at all, not even your prescribed tablets, from 9 pm the night before E.C.T.
2. DON'T smoke on the morning of E.C.T. - and preferably, give up smoking altogether throughout your course of E.C.T.
3. DO - tell your doctor of any drug allergies or previous problems with anaesthetics.
4. DO - if you're an outpatient - arrange for someone else to drive you to hospital for your E.C.T. and take you home again afterwards. Never drive your car on the day you're having E.C.T., and ask your doctor about driving at other times.

APPENDIX H. Wellington Hospital Patient Code of Rights

PATIENTS HAVE THE RIGHT TO:

- know the names and roles of people looking after them
- be told about their illness and treatment
- make suggestions about their treatment
- reasonable privacy when they need it
- choose whether or not they want to be used in teaching or research
- leave before being discharged, but this is done at the patient's own risk

PATIENTS MUST:

- be helpful to staff and tell them of any change in their illness
- be considerate to other patients

Patients are encouraged to ask staff about their illness and treatment, and about anything else of which they are unsure. They should feel free to make suggestions about anything which affects their own or other patients' wellbeing.

1 Patients are entitled to considerate and respectful care regardless of their age, sex, race or culture, or their economic, educational or religious background.

2 Patients should be told the name of the doctor who is responsible for their care, and the names and roles of other staff attending them.

3 Patients are entitled to be told as much as they want to know about their illness, their course of treatment, and likely outcome, by the doctor responsible for their care.

4 Patients are entitled to be given as much information about any treatment or procedure, as they may need to consent to, or refuse the procedure or treatment. This information and any other communication should be given in a language which the patient understands and where a communication is significant to the patient, it should take place in an atmosphere which encourages discussion. Except in emergencies, information about a treatment should include a description of the procedure, other possible courses of treatment, and the risks involved in each. Patients are encouraged to ask for such information if it is not given.

5 Patients are encouraged to, and should be assisted to, take part in decisions about their care and treatment. This includes the right to refuse treatment and to be told what the possible outcome of this is. Refusal of any treatment can render a patient liable to be discharged from hospital. The Board will not be responsible for any harmful effects suffered by a patient who does not undergo treatment prescribed, or leaves a hospital against the advice of the staff attending him.

6 Except in cases of minor procedures to which a conscious patient raises no objection after having been informed of the nature of the procedure, no surgical operation shall be performed upon a patient unless and until a consent has been signed by or on behalf of the patient. In emergency where a relative or guardian is not available the Medical Superintendent or his deputy shall give consent.

7 Patients are entitled to reasonable privacy when receiving treatment. Case discussion, consultation, and examination and treatment are confidential and should be conducted discreetly. Patients should be told the reason for the presence of anyone not directly involved in their care.

8 Patients should be aware that while the Hospitals Act 1957 protects the confidentiality of their medical records, it also allows the Medical Superintendent or his deputy to disclose information required in the course of their official duties by certain officers of the Department of Health and other Government departments.

9 Patients wishing to leave the hospital voluntarily before the conclusion of treatment and against the advice of the doctor under whose care the patient has been placed will be expected to sign a statement to that effect.

10 Any patient who is dangerously ill, wishing to leave the hospital or to be removed by his relatives or friends, shall be allowed to leave only after the matter has been discussed with the Medical Superintendent or his deputy.

11 Although the Wellington Clinical School of Medicine has access to all the Board's hospitals for teaching purposes, patients will not be included in any research project affecting their care and treatment until they have given their informed consent* to take part. Patients are free to decline to take part or to withdraw their consent at any stage.

12 Patients are entitled to be informed by the hospital doctor and nursing staff what is necessary for the care of their health after leaving hospital.

* The basic elements of informed consent are:

1 A fair explanation of the procedures to be followed, including an identification of those which are experimental.
2 A description of the attendant discomfort and risks, if any.
3 A description of the benefits to be expected.
4 An offer to answer any enquiries concerning the procedure.
5 An instruction that the patient is free to withdraw his consent and to discontinue participation in the project or activities.

RESPONSIBILITIES:

1 Patients have a responsibility to be open and honest with Hospital Board staff about the instructions they receive concerning their health. Patients should let staff know immediately if they do not understand the instructions or feel that they cannot follow them. Patients have a responsibility to inform the hospital if they are unable to keep appointments.

2 Patients have a responsibility to co-operate with nursing staff and with their doctor and to let them know any change in their health while in hospital.

3 Patients have a responsibility to show consideration for other patients and to see that their visitors are considerate as well and observe hospital rules.

4 If a close relative or friend wishes to stay with a child or with a seriously ill or dying patient this should be discussed with the nurse in charge of the ward or unit at that time.

5 In the case of special, or committed patients in psychiatric hospitals and units, some important qualifications exist in respect of the right to consent to or refuse treatment, and the right to discharge oneself from hospital against medical advice. For such patients, the hospital staff are given rights and responsibilities under the Mental Health Act 1969 which may overrule the patient's wishes if such action is considered necessary for the health, welfare or safety of that patient or other people.
Such powers will be used with discretion, and agreement will normally be sought from the patient or his relatives where practical, but for such patients many legal rights and responsibilities do rest with the Medical Superintendent and his delegated representatives.

Staff have a responsibility to ensure that patients are informed that a Code of Rights exists and to ensure that a copy is made available to them.

In the case of patients who have a poor comprehension of English, Staff should take steps to see that wherever possible the patient has the services of a suitable person who can explain the Code in the patient's own language.

PATIENTS' RIGHTS UNDER THE MENTAL HEALTH ACT

The general statement of patients' rights and obligations adopted by the Wellington Hospital Board should be on display in each ward of this hospital. In addition, there are some particular points about the Mental Health Act which are often important.

Legal Status

Most patients are admitted here as informal patients. Some come under the formal sections of the Mental Health Act and are known as certified or committed patients. If you are in doubt about your status, ask a nurse to find out the facts. If you want to discuss the implications of your status, you should usually do this with your doctor or the ward charge nurse.

Informal patients have accepted advice to be admitted and their legal position is the same as any ordinary patient at a general hospital. Details of their treatment and their length of stay in hospital are matters of mutual cooperation between the patient and the medical and nursing staff here.

If you have been certified, it means that two doctors have written formal certificates saying that you need to be in hospital for the sake of your health. Those certificates give the hospital a legal right to admit and treat you. Within 21 days, if committal is to be recommended, the hospital must notify a District Judge who will examine the papers, speak to the hospital staff, and usually to the patient. If the judge is satisfied that everything is in order, he may then make a committal order, which authorises the hospital to continue treating you. A certified patient, or his/her relatives, may ask for a judge to enquire into their admission earlier than the usual 21 days, and the hospital must send such a request to a judge within 48 hours.

Not every patient admitted under formal certificates is later committed. Many patients improve during that 21 day period, and the hospital can then let them be informal patients, or discharge them.

Complaints Procedures

It is inevitable that some patients will wish to raise complaints at times. The following procedures are available:

1. Always raise such matters first with your doctor or ward charge nurse, who will usually be able to deal with them.
2. If you wish to take a matter further within the hospital, you may send a note to any member of the hospital management team, ie, Medical Superintendent, Principal Nurse, or the Director of Administration.

3. Any patient has the right to send a letter to their Member of Parliament, a judge, the Ombudsman, the Minister of Health or the Director of Mental Health in the Health Department, or to the District Inspector for the hospital.

   Mr R Pethig has just resigned from the post of District Inspector and we are awaiting the appointment of his replacement. The name and address of the new District Inspector will be attached below. The District Inspector is a lawyer and is not connected with the hospital staff.

4. If you want to discuss something with a person outside the hospital, but don't wish to approach one of those official persons mentioned above, you may find it helpful to contact the Citizens' Advice Bureau, or a lawyer of your own choice.

Effects of Committal

People are often worried by mistaken ideas, such as thinking that committal means they will stay in hospital for ever. In fact, it is hospital policy to reduce the number of patients in hospital, if possible, and we try very hard not to keep patients in hospital unnecessarily. It is true that committal does give the hospital a legal right to treat and to detain a patient, but we only use that right if it is considered medically necessary to do so.

The present law rules that the financial affairs of every committed patient come under the management of the Public Trust. It is possible for the patient's family to make special arrangements for a lawyer of their choice to act.

Financial control is administered as discreetly as possible, and is intended to be for the assistance and protection of the patient and his family.

A committed patient is required to surrender his driving licence, but this can be given back when the doctor thinks you are well enough. Generally speaking, committed patients retain their other legal rights, and in particular they are entitled to vote.

A request can be made to the District Inspector or to the Minister of Health for a legal review of any committal.

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