BUDDLE FINDLAY

Legal update on health law - December 2014

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Charges dismissed, but Tribunal comments on inadequate communication

The Health Practitioners Disciplinary Tribunal has dismissed charges brought by the Director of Proceedings against a General Practitioner, finding that there was insufficient evidence of any inappropriate intimate examination by the doctor.

However, the Tribunal commented on the apparent inadequacy of the doctor's communication, noting that if there had been better communication at the time "*there would have been no misunderstanding on the part of the Patient as to what was required of her and what the Doctor was proposing to do and the reasons behind this*" (the doctor's evidence was that she had removed her underwear to the level of her mid-upper thigh when this was not necessary for the examination that he was undertaking). The Tribunal noted that: "*A doctor should be punctilious to verbalise clearly what he or she is planning to do and doing and why. … there must be adequate information provided before consent can be given by patients*", and emphasised that this is particularly important when undertaking intimate examinations. The Tribunal also noted its view that the doctor should take advice and courses on communication and should seek recommendations from the Medical Council. The doctor was granted permanent name suppression following a majority decision of the Tribunal. *653/Med14/281D*

Protocol written by doctor is not the yardstick for establishing negligence

A doctor who provided medical services at a retirement village was charged with professional misconduct on the basis that he failed to adequately follow up and investigate the cause of abnormal blood tests for a resident patient.

While the doctor admitted the charge and that the care provided clearly did not follow the protocol that the doctor himself had developed, the Tribunal noted that it was required to assess the charge independently and reach its own view on it. The Tribunal said that "*The Protocol written by the Doctor is not the standard against which to determine whether he has discharged his professional responsibilities… Although a medical practitioner may have self-prescribed standards in one form or another… it does not follow that those standards are necessarily the objective professional standards required of the medical practitioner*". As the charge proceeded on the basis of an agreed statement of facts, the Tribunal did not have evidence before it about such standards and had to reach its own conclusions from its own expertise. The Tribunal concluded that there was not a failure on the part of the doctor, and that any abnormality shown by the blood tests was below levels which called for intervention. The Tribunal also criticised some aspects of the Protocol noting that "*the requirement for all patients to have routine 3 monthly blood and urine tests is not consistent with good medical practice. Blood and urine tests should only be initiated if there is a clinical indication to do so. Doctors should be able to justify why they are ordering a test and whether it is beneficial to the patient*". *652/Med14/282D*

Name suppression granted to doctor to protect wife

Dr X pleaded guilty before the Health Practitioners Disciplinary Tribunal to two charges of professional misconduct (involving sexual intimacy with a patient). The Tribunal decided to grant Dr X's wife, but not Dr X, name suppression. The High Court upheld Dr X's appeal, with the effect that both Dr and Mrs X now have name suppression.

In overturning the decision of the Tribunal, the High Court found that "*an order preventing publication only of Mrs X's name is largely ineffective*", and that if the Tribunal "*considered that protection of Mrs X was necessary for health reasons, then name suppression for Dr X was the only realistic mechanism*". As it stood, it was "*quite difficult to give effect*" to the Tribunal's order, as the order extended to Mrs X's "*identifying details*", and naming Dr X would identify Mrs X to everyone who knows her. Accordingly, the Court found that in order to protect Mrs X's identity, "*suppression of Dr X's name is the only outcome*". The Court also noted that the unusual aspects of this case made the "*outcome of name suppression less troubling than usual*", and the "*outcome will have minimal precedent value*".
X v Director of Proceedings [2014] NZHC 1798

Costs awarded against Director of Proceedings

The Human Rights Review Tribunal has awarded costs to an iridologist and natural health practitioner against whom proceedings were brought by the Director of Proceedings, despite the Director having been successful in obtaining judgment that the practitioner had breached the Code of Rights.

In the substantive proceedings, the Tribunal had found that the practitioner breached the Code of Rights in relation to only one of the eight alleged breaches. In the hearing regarding costs, the practitioner submitted that the majority of the allegations made against her were not established, and the Tribunal was greatly assisted by an expert witness that she had arranged at her own cost. In determining the novel issue of whether costs can be awarded against an apparently successful party, the Tribunal confirmed its jurisdiction and awarded the practitioner $5,000. The Tribunal commented that "*while the Director brings proceedings under the HDC Act in the public interest, care must be taken not to overwhelm a defendant and overburden the Tribunal's processes by alleging breaches of every conceivable provision of the Code of Rights*". It was held that where the Director is largely unsuccessful the cost of defending such proceedings is not a burden which should be borne by the defendant alone. *Director of Proceedings v Nelson (Costs)* [2014] NZHRRT 33

Fluoride Free advertisement in breach of Advertising Standards

The Advertising Standards Authority Complaints Board has upheld a complaint about an advertisement on the Fluoride Free NZ website that stated: "*Informed Doctors and Dentists say: KEEP FLUORIDE OUT…Swallowing Fluoride: is unsafe for babies; doesn't protect teeth; can cause harm*", and found that an advertisement by the Ministry of Health for fluoride could be distinguished.

The Complaints Board found that, unlike the Ministry's advertisement, the claims in the Fluoride Free advertisement were not corroborated by evidence. As the claims were presented as fact, rather than opinion, but were not substantiated by the advertiser, they were not saved by the allowance for robust opinion in advocacy advertising, and were likely to mislead. In addition, the claim that swallowing fluoride is "*unsafe for babies*" and "*can cause harm*" unjustifiably played on fear. The Complaints Board concluded that the advertisement was socially irresponsible. *Fluoride Free NZ website Advertisement* [2014] NZASA 460

High Court rejects anti-fluoride bid

In October 2014 the High Court dismissed an application to classify hydroflurosilicic acid and sodium silico fluoride as medicines when those substances are used to fluoridate water.

The judgment did not address issues relating to the efficacy and safety of fluoridation . However, the decision should provide comfort to Councils and District Health Boards about the current rules relating to fluoridation of water supplies. For a more detailed update on this decision, click here.

Criticism for implementing palliative care without reviewing all relevant information

A recent case where an elderly patient was commenced on palliative care without having his large tension pneumothorax diagnosed highlights the importance of having clear directions about individual responsibilities within clinical teams. The case also emphasises the importance of ensuring that all relevant information is reviewed before a decision to withdraw active treatment is made.

The patient had gallstones and required urgent surgery. Immediately after surgery, the patient was having breathing problems and the anaesthetic team asked the ICU nurse to arrange a chest x-ray. The x-ray was undertaken, but no member of the team reviewed the results. The patient's condition continued to deteriorate and, after further discussions, palliative care was commenced. A short time after the patient had died, the patient's post-operative x-ray was reviewed and a large tension pneumothorax was discovered. After investigation, the Commissioner commented that the three main failures in this case were poor communication, a failure to consider differential diagnoses and"*a lack of clarity from [the DHB] about who was ultimately responsible for ordering and reviewing a post-operative [chest x-ray]*". Ultimately, while the Commissioner did make some adverse comment about the individual clinicians, the Commissioner concluded that the failures were "*directly attributable to [the DHB*]" and the DHB was found in breach of Right 4 of the Code of Rights. The Commissioner also criticised the ICU consultant's decision to commence palliative care without ensuring that all relevant information had been reviewed. *12HDC01133*

Lack of forward planning leaves paralysed client without services over Christmas break

A home care provider who failed to provide a client with her scheduled support services for more than a week over the Christmas break has been found in breach of the Code of Rights and prosecuted before the Human Rights Review Tribunal.

The client, who was paralysed from the chest down, was assessed as requiring eight hours of care per day as well as overnight support. In the months leading up to the Christmas period, it became apparent that the client's usual carers would not be available . However, despite attempts by the client and the care provider, the provider was unable to arrange alternative cover and the client was left for more than a week without full care services. On investigation, the Deputy Commissioner accepted that it can be difficult to find and recruit suitable carers in small rural towns. However, the Deputy Commissioner concluded that "*the factors that led to this serious lapse in care were not recruitment and retention issues*" but rather "*the key failing by [the provider] was its failure to forward plan and communicate effectively*". The Deputy Commissioner was also "*very concerned*" by the provider's responses to the client's complaints, commenting that the responses "*showed a total lack of empathy and regard for [the client's] situation*".

The provider was found in breach of Rights 4 and 1 for failing to arrange appropriate care, placing the client at an increased risk of harm, and failing to treat her with respect. The provider was referred to the Director of Proceedings and a case was laid before the Human Rights Review Tribunal. The Tribunal noted that the provider accepted that it had breached the Code and concurred and issued a public declaration to that effect. *13HDC00164* and *Director of Proceedings v Healthcare of NZ Ltd* [2014] NZHRRT 46

Series of missed opportunities delays cancer diagnosis

The Commissioner has found a DHB and two clinicians in breach of the Code of Rights after a series of systemic and individual failures resulted in a missed opportunity to diagnose a patient's lung cancer.

The patient had an anaesthetic assessment in preparation for dental surgery and the anaesthetist requested a chest x-ray. The x-ray was undertaken and an abnormal opacity on the lung was noted. The radiologist reported the abnormality but did not 'red flag' the result. The report was automatically sent to the dental unit, but no clinician reviewed the results. The report was not copied to the patient's GP or to the referring anaesthetist. When the patient attended for surgery she was seen by a second anaesthetist who did not conduct a full pre-operative assessment. Approximately a year later, the patient was diagnosed with an inoperable carcinoma with metastases. On investigation, the Commissioner stated that "*the lack of follow up occurred because of a number of organisational and systemic failures, including the lack of clearly established and explicit processes for following up investigation test results, and poorly understood lines of responsibility, coupled with associated deficiencies on the part of a number of individual clinicians*". The DHB was found in breach of Right 4 for the systemic failings. The radiologist was also found in breach (for failing to 'red flag' the result), as was the second anaesthetist (for failing to address the patient's heart murmur during the pre-operative assessment). The Commissioner also made a number of other adverse comments about the care provided. *12HDC00112*

Failure to provide adequate anaesthesia and 'striking lack of empathy' during caesarean-section

An anaesthetist and an obstetrician have been found in breach of the Code of Rights after a patient was provided with insufficient anaesthesia during a caesarean-section.

In addition to the failure to provide sufficient anaesthesia (for which the anaesthetist was found to have breached the Code), the Commissioner also criticised the anaesthetist for his communication style. Among other things, the Commissioner found that the anaesthetist had increased the patient's anxiety by placing an "*ill judged*" and "*insensitive*" emphasis on the risk of death from a general anaesthetic. The Commissioner concluded that the anaesthetist's communication with the patient "*displayed a lack of sensitivity, and he treated [the patient] with a striking lack of empathy*". The obstetrician was also criticised by the Commissioner for failing to act more assertively when she knew her patient was in pain: "*As a responsible clinician, she should have spoken and acted with more authority…*". The Commissioner found both clinicians in breach of Right 4 of the Code, and the anaesthetist was referred to the Director of Proceedings. *13HDC00515*

Communication failures see breach findings against a DHB, surgeon and anaesthetist

A DHB, a surgeon and an anaesthetist have been found in breach of the Code of Rights in relation to their care of a patient who refused a blood transfusion. The patient died following what was expected to be a routine laparoscopic cholecystectomy.

At the time of surgery the surgeon was not aware that the patient would not consent to blood products, despite the patient advising certain DHB staff of this, and the surgical safety checklist being completed by the surgical team. It was only when the patient had to be returned to theatre due to internal bleeding that the surgeon discovered her refusal of blood products. The Commissioner found the DHB in breach of Right 4 because its systems and processes did not bring the patient's refusal to the surgeon's attention, and because there was a failure in effective communication and co-operation by the surgical team. The Commissioner noted that "*DHBs must have clear, robust processes that support the timely communication of relevant information*", and that "*concerns specific to the case and patient must be raised by any member of the theatre team who is aware of them...DHBs must promote an organisational culture that encourages [all staff to raise issues]*". The Commissioner also commented that staff should not have asked the adult patient's mother to override the patient's refusal of blood, as this was a decision that the mother "*was not entitled to make*". The surgeon was found in breach of Right 4(1), as he did not read the patient's notes sufficiently to obtain information he needed before commencing surgery, which in turn had implications for providing the patient with relevant information and obtaining her informed consent. The anaesthetist was found to have breached Right 4(5), for not raising the patient's refusal of blood products with the team. The Commissioner noted that "*good continuity of care is reliant on a high standard of communication, checking and testing of assumptions, and confirming a mutual understanding*", and said that although the risk of requiring a transfusion was low, treatment with blood products was an issue of significance to the patient and her refusal should have been raised with the team and documented on the consent form. *11HDC00531*

Sharing information about vulnerable children

The Privacy Commissioner and the Children's Commissioner have released a guidance document to assist social service agencies and their employees to make sound and lawful decisions about the sharing of personal information about families and vulnerable children.

The guidance document notes that sharing information with other social service is often essential to an individual's health, safety and wellbeing, and that it can often take the effort of a number of agencies, working effectively together, to address the multiple and complex needs of that person or family. The guide is designed to clarify the laws around sharing personal information; offer practical suggestions and tips for managing information sharing; explain how Approved Information Sharing Agreements can work; and identify specific information sharing issues that affect children and vulnerable adults. Further information is available here.

Privacy Commissioner releases new naming policy

The Privacy Commissioner has released a new policy that records his Office's "willingness" to publicly name agencies in appropriate cases and outlines the considerations that would make the naming of an agency "more likely", or "less likely".

The decision to identify respondents to complaints is intended to increase agency attention on privacy, serve as an example to others to encourage compliance, and facilitate consumer education. Factors that would make the Office more likely to name an agency that has breached privacy requirements include that: the agency's conduct is likely to have affected persons in addition to the complainant; there has been a very serious breach or repeated lesser breaches; the agency has demonstrated an unwillingness to comply with the law; or publication would be in the public interest (for deterrent or educative purposes). Further information, including a copy of the Policy, is available here.

Update on the health legislation programme

Health-related bills back on the legislative programme for the current Parliament include:

- The Health (Protection) Amendment Bill, which proposes amendments to the Health Act 1956 to improve the tracing of people who may have had or may be exposed to infectious diseases and increases the range of diseases that are notifiable. The Bill includes new proposals for management of individuals with such diseases and introduces a ban on sunbeds under 18s. The Bill had its first reading on 6 November 2014
- The Coroners Amendment Bill, introduced in July, which makes a number of amendments arising from the review of the Coroners Act 2006, such as changes to coronary investigations and clarifying the role of coroners (eg reducing duplication between coroners and other authorities investigating deaths and accidents)
- The Smokefree Environments (Tobacco Plain Packaging) Amendment Bill, which was reported on by the Health Committee on 5 August 2014

- A number of Bills which had been stalled for some time, such as the Natural and Supplementary Products Bill and the Public Health Bill
- The SuperGold Health Check Bill (a Member's Bill from the Rt Hon Winston Peters), which provides SuperGold card holders with an entitlement to three free doctors' visits per year.

The Therapeutic Products and Medicines Bill was discharged on 24 November 2014, following a joint announcement by the Ministers for Health in New Zealand and Australia that the two countries were going to cease efforts to establish a joint therapeutics product regulator.

PHARMAC expands into new medical device category

PHARMAC has extended the range of products which it has under national contracts, by listing those used in cardiac procedures. The change is expected to enable DHBs to make significant savings in cardiac medical devices. The 303 items now listed on the Pharmaceutical Schedule are the first in what is likely to be a large number of interventional cardiology medical devices available at national prices.

Psychoactive substances

Three sets of Psychoactive Substances Regulations came into force on 3 November 2014:

- The Psychoactive Substances Regulations 2014
- The Psychoactive Substances (Fees and Levies) Regulations 2014
- The Psychoactive Substances (Infringement Fees and Form of Notices) Regulations 2014.

Psychoactive substances are ingredients used in different drugs that affect the mind (eg party pills, herbal highs). The 2014 amendments to the Psychoactive Substances Act 2013 introduced a moratorium on applications for product approvals and licences, and revoked approvals for interim psychoactive products. The Regulations do not lift the moratorium (as licences for wholesale and retail sale cannot yet be issued), but they enable potential importers and manufacturers to develop their systems in order to meet the new requirements (which closely resemble the pre-market approval regime for medicines). There will be more stringent requirements, including a "*fit and proper person*" test. Conditions will also be placed on licences, which must be met on an ongoing basis. The intention is that psychoactive substances will be able to be sold again in the future, but only after they have gone through a pre-market assessment for quality and safety. Only low risk products will be allowed to be sold.

New rules about charging for premium rooms and additional services

From 1 July 2014, new rules have been in place that provide clarity around when a facility may charge a resident for a premium room or bed, when standard rooms are not available.

The rules, which set out when a resident will or will not be charged for a premium room or additional services, have been included in the 2014-15 Age Related Residential Care agreements. The rules were based on the following key principles:

- The need to ensure that all older people who are assessed as requiring Aged Residential Care will be able to access care, regardless of whether they wish to pay additional charges
- The need to always have "local" availability of beds, without an additional charge
- The principles need to be enduring - that is no detailed schedules which simply enable people to work around the principles.

For more information (including a flowchart that sets out how the new charging rules work) click here.

Free doctors' visits and prescriptions for under 13s

The Government announced in this year's Budget it would invest NZ$90m over three years to extend the zero fees for doctors' visits and prescription co-payments for children aged under six, to children under 13.

The Ministry of Health has been working with the PSAAP group to consider policy implementation issues, including utilisation, co-payments, subsidies and clawbacks. The intention is to reach formal agreement before Christmas, giving DHBs and PHOs time to work with their general practices to meet the 1 July 2015 implementation date.

Health Systems Law Intensive 2015

Buddle Findlay is pleased to confirm that we will be running the Health Systems Law Intensive in Wellington from 7 April - 10 April 2015 in conjunction with the University of Otago and Claro. This intensive will be taught by senior lawyers who have worked with, and in, the health sector for many years, and senior academics from the University of Otago Faculty of Law. The course is designed specifically for senior clinicians, board members, chief executives, and senior managers working in the New Zealand health sector. Enrolment is also open to post-graduate law students and practising lawyers with an interest in the field of health law. For further information, or to enrol, please contact judy.woolley@buddlefindlay.com.

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