BUDDLEFINDLAY

Legal update on health law - August 2014

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26 August 2014

Inmate on hunger strike permitted to refuse treatment

The Department of Corrections (the Department) and Canterbury District Health Board sought a declaration from the High Court that they have a lawful excuse for not providing treatment to a prison inmate on a hunger strike. Alternatively, the Department sought a declaration that artificial hydration and nutrition may be provided to the inmate where his health or life is in peril and he is not able to indicate whether he consents to treatment.

The inmate directed that he was not to be hydrated and fed, either at prison or hospital, including in the event that he becomes incapable of giving or refusing consent to medical treatment. This was of particular concern to the Department, as the Corrections Act 2004 imposes a duty on the Department and its staff to ensure "*the safe custody and welfare of prisoners*". In addition, the Crimes Act 1961 and the Corrections Act 2004 authorise the use of reasonable force and, in the prison setting the use of restraint, to prevent suicide, injury or self-harm. The Court noted that the inmate had been assessed by four psychiatrists, all of whom agreed that there was no indication he suffered from a mental disorder, and the Judge was "*in no doubt that he is competent to have given the indications he has in relation to medical treatment*". The Court found that there was no justification to limit the right to refuse medical treatment (section 11 of the New Zealand Bill of Rights Act 1990), and considered the "*ethical dilemma that would be cast upon doctors if section 11, the right of a patient to refuse treatment, was not respected*". The Court made a declaration that: "*Persons owing a duty of care to [the inmate] will have lawful excuse for not providing medical treatment to him while he continues not to give informed consent to such treatment, or an advance directive refusing consent is in place*". *Department of Corrections v All Means All* [2014] NZHC 1433

DHB successfully applies to strike out primary and secondary victim claims

The High Court has struck out a number of claims brought against a DHB by a stroke survivor who suffered a fall in her home while receiving home care services from a DHB-funded provider, and by two family members who witnessed the fall and suffered "*devastating emotional trauma*".

The plaintiffs, who were self-represented, relied on a number of the rights contained in the Code of Rights. While noting that the Code provides for remedies under the Health and Disability Commissioner Act 1994 only, not the civil courts, the Court commented that the DHB was not a 'provider' at the time of the fall in her home. The Court also found that, at common law, the DHB could not be vicariously liable for the actions of the allegedly negligent employee of the homecare provider, but declined to address the question as to whether the DHB, as funder, owed a direct duty of care as this was unnecessary given the fact that the ACC bar provided a complete defence to this aspect of the claim. The ACC bar did not apply to the family members' claims for mental injury; however, the Court found that they could not establish that they were suffering from a recognisable psychiatric disorder or illness. Their claim was struck out accordingly. *Xi v Howick Baptist Healthcare Ltd* [2014] NZHC 1058

Inappropriate accessing of electronic records, including the nurse's own

A nurse who accessed the electronic records of her former husband and his new partner (among others) without their knowledge or consent has been found guilty of professional misconduct, censured, suspended for five months and ordered to pay $20,000 in costs. Interestingly, the Tribunal also found that the nurse acted inappropriately, and failed to adhere to the relevant legislative and professional requirements relating to information privacy, when she accessed her own records and records of family members (her son, and three others at their request), but that, in the particular circumstances, the conduct did not meet the threshold for discipline.

The Tribunal confirmed that health practitioners are only authorised to access a patient's notes when required for that patient's care, and that requests for the practitioner's own records, or those of family members, must be made through the correct channels and following the correct procedures. By way of example, the Tribunal referred to the position regarding children, noting that while a child's guardian may seek the child's health information, "*proof of that person's status must be*

given; further the health agency has to be able to exercise its discretion under section 29(1)(d). If release of a child's information would be contrary to their interests (such as in a disputed parenting context), a health agency has the right not to provide the information. The opportunity to exercise this discretion has to be provided; it cannot be by-passed". In deciding that this access did not warrant discipline, the Tribunal noted (among other things) that the nurse was well motivated, believed she was entitled to access the information, and that the DHB did not provide specifically for urgent requests for health information in its guidance or application form. The nurse was, however, disciplined for accessing other patients' information without their knowledge and consent and for inappropriately using confidential patient information that she had obtained. *Nurse S* 623/Nur13/256P

Practitioner should have refused to accept funds from dying patient

A doctor has been found guilty of professional misconduct for accepting $150,000 from a terminally ill patient who, in the course of winding up his estate, wanted to leave the money to the doctor's surgery to help the people of the local community with their health needs, and to help them access medical services.

While the Tribunal found that patient had appropriate decision-making capacity, and there was no undue influence ("*for instance there is no evidence that [the doctor] suggested the transaction, or that he set about arranging matters to benefit himself personally. The evidence suggests that it was [the patient] who raised the issue and who was adamant that he wished to proceed*"), the Tribunal concluded that the transaction should not have proceeded. The Tribunal was also satisfied that the doctor's failure to make or file any record of the transaction or the discussions that he had with the patient in the medical records was a significant breach of appropriate standards. The Tribunal censured the doctor, and ordered him to pay a fine of $7,500 and costs. A second charge, this time relating to a conviction for obtaining a pecuniary advantage by deception (inflated or fictitious travel and expense claims submitted to ACC) resulted in further penalties, including a six month suspension. *Dr Wright* 624/Med13/263P

Coroner finds that failure to promptly address a known medication error contributed to patient death

A 96 year old rest home resident was accidentally administered medications intended for another resident. Despite realising the error, the caregiver continued with her medication rounds before notifying the on call nurse. Further delays by nursing staff followed, resulting in the patient being admitted to hospital over four hours after the error, where she subsequently died. Inquest findings have been released and are critical of the actions taken by rest home staff.

The rest home's processes for medication administration included wearing a "do not disturb" apron during the medication rounds, doing the "five right check" (right person, medication, time, route and dose) before administering medication, and taking all medications for a patient to that patient's bedside at the same time. In this case, the caregiver was distracted by another resident and left the medication round to assist him. On returning to the trolley, she picked up a blister pack for another resident and administered it to the patient. Coroner Devonport found that the caregiver's delay in contacting the on call nurse following the error was "*unacceptable*", as was the failure by that on call nurse to contact a doctor and seek medical advice and the second nurse's delay in summoning an ambulance. The Coroner concluded that the patient "*was badly let down by the actions of staff at [the rest home]*" and noted that "*had there been more prompt notification by the care giver to nursing staff of the medication error, the immediate contact by nursing staff with a doctor, and more prompt summoning of ambulance assistance, the chance of the lethal effect of the medication error being overcome would have increased significantly*". *Borgen* (30 May 2014)

Hoist management issues result in patient death

During a hoist transfer at a rest home, part of the hoist collapsed and the resident fell to the floor, hitting her head on one of the metal hoist bars. She died from lobar pneumonia as a complication of the severe head injury she suffered. At the inquest, the Coroner found that the standard of care "*fell short of the standard required*" and made a number of recommendations regarding hoist management.

The evidence presented during the inquest indicated that modifications made to the hoist caused the accident, and that it was"*inevitable*"that an accident of this nature would occur at some stage. Coroner Bain noted his concern that there was no record of who had modified the nut and bolt or when the modification occurred, and his concerns about the recent service of the hoist, particularly the fact that a load test was not recorded as being undertaken. The Coroner commented that the case "*demonstrates the need for high standards in checking medical devices*". The Coroner chose to list all of the recommendations submitted by counsel, on the basis that appropriate authorities can consider which recommendations should be adopted and enforced. The recommendations included keeping a running log for each piece of biomedical

equipment within a medical facility; ensuring that safety features of equipment are communicated to staff and that staff receive adequate training, including on how to conduct a visual check of the equipment before each use; and ensuring that equipment that fails during use is immediately removed from service. *Wilson* (16 May 2014)

Broadcasting Standards Authority upholds doctor's complaint about television show

A television show aired a story about experimental stem cell treatment provided by a New Zealand doctor. The story included footage that had been covertly obtained by a patient during a consultation. The doctor complained to the Broadcasting Standards Authority (the Authority), alleging that the story breached his right to privacy and was unfair.

The Authority upheld the doctor's complaint, finding that the show had breached the privacy and fairness standards. In particular, the show was criticised for failing to provide the doctor with a fair and reasonable opportunity to comment on the proposed broadcast. The Authority also found that the use of a hidden camera breached the doctor's privacy and, as the broadcaster had inadvertently destroyed the full copy of the raw footage, the broadcaster could not demonstrate that the level of public interest in the showing footage outweighed the breach of privacy. The Authority concluded that while "*some of the circumstances surrounding [the doctor's] therapies and practices justified their being questioned and examined*", ultimately the broadcaster "*did not secure itself the protection of putting forward a broadcast that was compellingly in the public interest. The result is that the complaint must be upheld...*". The broadcaster was ordered to pay $5,500 toward the doctor's legal costs. *Dr Z and Television New Zealand Ltd* (2012-074)

Breach of Code for disrespectful manner and failure to respond to concerns raised by colleagues

The Commissioner has found an obstetrician in breach of the Code for various failures in the care he provided to a patient during labour, including his failure to heed concerns raised by his registrar colleague. The Commissioner took the opportunity to remind providers about the importance of "*doing everything possible to voice [your] concerns and advocate for the patient...*".

The obstetrician was called for assistance after concerning CTG results. On arrival, the consultant's communication with the patient was "*minimal*" and the patient felt uncomfortable because of the consultant's "*aggressive*" manner. The consultant decided to wait until the obstetric registrar arrived to take a fetal blood sample. The midwife felt uncomfortable about this delay, but did not voice her concerns. On arrival, the registrar raised her concern that an emergency C-section was immediately necessary, but was instructed by the consultant to continue with the blood sample. The patient was taken for an emergency C-section after the sample was taken, but the baby was unresponsive and resuscitation attempts were unsuccessful. The obstetrician was found in breach of the Code for (among other things) his disrespectful manner and failure to provide the patient with appropriate information about her care plan, and his failure to respond to the registrar's concerns and proceed to a C-section in a timely manner. The Commissioner also made adverse comment about the midwife's failure to raise her concerns, and endorsed the registrar's decision to raise her concerns, albeit without success. 12HDC00846

GP found in breach for failing to properly monitor and communicate test results

A GP has been found in breach of Rights 4, 6 and 7 of the Code for failing to adequately monitor a patient's lithium levels and renal function, and failing to inform the patient about abnormal test results.

A patient on an established programme of lithium treatment transferred to a GP's care. Over the next five years, the GP continued to prescribe lithium, but did not discuss the associated risks with the patient. The Commissioner also found that the GP's monitoring was inconsistent, the GP failed to take action when abnormal test results were reported, and failed to take heed of a specialist's suggestion to reduce the dosage. The Commissioner concluded that the GP failed to provide services with reasonable care and skill, and that his failure to inform the patient of his abnormal test results breached the patient's right to make informed choices about his treatment. The Commissioner also noted that: "*prescribing providers, whether or not they are initiating treatment, would be wise to satisfy themselves that the consumer is aware of known material risks associated with the medication that the provider is prescribing*". 13HDC00048

Commissioner 'alarmed' by counsellor's lack of awareness of conflict of interest

A counsellor who failed to recognise the conflict created by providing ongoing counselling services to a husband and a wife during the couple's separation has been found in breach of the Code. The Commissioner also criticised the counsellor for

failing to treat her client with respect and for advising on legal and financial matters outside her field of expertise.

The wife engaged the counsellor for relationship counselling and subsequently requested joint sessions with her husband. The couple had a number of joint sessions before they decided to separate. The counsellor then continued to provide both the husband and wife with individual sessions. On investigation, the Commissioner noted the counsellor's ethical and fiduciary duties to ensure that the counselling relationship was not compromised by an actual or perceived conflict of interest. The Commissioner emphasised that: "*[i]f during counselling a conflict of interests emerges that may impact on his or her ability to act impartially, a counsellor must clarify, adjust, or withdraw ...*". The Commissioner commented that the counsellor's lack of awareness and failure to recognise the conflict was "*alarming*" and concluded that the counsellor had breached Right 4(2) of the Code. 12HDC01512

Breach of Code for administering penicillin to a patient with known allergy

A doctor who failed to check whether a patient had any allergies before administering medication has been found to be in breach of Right 4(1) of the Code. The Commissioner said that despite having seen the patient the previous day and being at the end of a busy shift, the doctor still had a responsibility to ask the patient about allergies and to check the patient management system.

The patient presented to an emergency clinic for antibiotics to treat cellulitis. The doctor, who remembered the patient from the previous day, wanted to assist her colleagues by reviewing the patient before finishing her shift. After reviewing the patient, the doctor decided to add another antibiotic "*forgetting that he was allergic to penicillin*". The Commissioner found that the doctor had failed to provide services with reasonable care and skill as she had "*missed several opportunities to ascertain [the patient's] allergy status, including reading the notes and asking her patient about allergies. In addition, if she had complied with the clinic's expectations with respect to prescribing... she would have become aware of the allergy*". 12HDC01062

Multiple breaches of Code by dentist providing "orthopaedic" dental care to child

A dentist has been found in breach of the Code for failures in the dental and "orthopaedic" care that he provided to young child. Among other things, the Deputy Commissioner noted that the treatment was consented to under the misconception that the dentist was a specialist orthodontist.

The Deputy Commissioner noted that the way the dentist described the treatment he provided had the "*potential to be misleading*", despite the fact that his patient information booklet stated that he was not a specialist orthodontist. In these circumstances, the Deputy Commissioner concluded that the dentist breached Rights 6(1) and 7(1) of the Code. The dentist was also found to have breached Right 4(1), as he "*did not obtain sufficient diagnostic information to assess [the patient's] condition adequately and to guide his treatment planning*", did not properly read a radiograph to identify pathology and advise on treatment options, and failed to monitor a tooth after restoration work. 11HDC01103

System failures result in unnecessary removal of fallopian tube and failure to return tissue

A DHB has been found in breach of the Code after a series of cumulative failures resulted in staff mistakenly removing a patient's only remaining fallopian tube and failing to return bodily tissues to the patient in accordance with her request.

The patient was referred to a hospital after an ultrasound showed a mass in her only remaining fallopian tube. The patient's fallopian tube was removed on the understanding that it was abnormal, without clinicians first checking the patient's pregnancy hormone levels or confirming the diagnosis by vaginal ultrasound. It later emerged that the fallopian tube was normal and the patient had a uterine pregnancy which was later terminated. On investigation, the Commissioner accepted his expert advisor's comment that "*given [the patient] had only one fallopian tube remaining, the duty of care for clinicians in this case was arguably even more exacting*". In the Commissioner's view, "*none of the above errors can be viewed in isolation from one another... the cumulative effect of a number of individual errors resulted in [the patient] receiving suboptimal care*". The Commissioner also found the DHB in breach of Right 7(9) of the Code for failing to return the products of conception to the patient in accordance with her request (forms were not completed correctly and the preoperative checking process did not identify this). 13HDC00487

Midwife failed to provide adequate information and carry appropriate equipment

Ms A had her first birth at home, attended by her LMC and a backup midwife. The foetus was not adequately monitored

during labour, and was born with the umbilical cord wrapped around its neck with thick meconium present. Neither midwife had oxygen available. Following a helicopter transfer to hospital, the baby died from intrapartum asphyxia.

During the investigation, the LMC said that she had suggested an episiotomy but that Ms A had refused consent. However, the Commissioner found that Ms A was not provided with sufficient information in breach of Right 6(1) as she "*was not advised of the risk to her baby if she stayed in the bath and decided not to have an episiotomy, and that she was not aware that local anaesthetic was available if she did have an episiotomy*", which was information a reasonable consumer would need to make an informed decision. The Commissioner also found that it was the LMC's responsibility to "*ensure the provision and availability of all home birth equipment*", and that she breached Right 4(1) for failing to ensure oxygen was available. The LMC was also found in breach of Right 4(2) for her "*concerning and unprofessional*" communications with Ms A, Ms A's mother, and other health professionals following the baby's death. 12HDC00460

Midwives referred to the Director of Proceedings

In three separate decisions, the Commissioner has considered the care provided by midwives and found that in each case there was a breach of Right 4(1) of the Code. All three midwives have been referred to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken.

In the first case, care for a woman who was 41 weeks plus four days gestation was handed over to a backup midwife for the weekend as the LMC was not available. The woman called the backup midwife at 4am on Sunday and told her that she had not felt her baby move on Saturday or at any time on Sunday morning. The Commissioner found that the midwife's response, which was to tell the woman to go back to bed and see if they baby moved after breakfast, was a "*severe departure from expected standards*". 12HDC01097

In the second case, the Commissioner found that care provided by the LMC was "*seriously suboptimal*" and that, among other things, the LMC had disregarded the recommendation of the obstetrician to perform continuous CTG monitoring and failed to adhere to expected DHB practice regarding monitoring of high risk pregnancies. The Commissioner noted that there was differing evidence as to why the CTG monitor was disconnected, but concluded that the removal of the monitor was not discussed with Mr and Ms A noting that: "*health professionals whose evidence is based solely on their subsequent recollections (in the absence of written records offering definitive proof) may find their evidence discounted*". 12HDC00214

In the third case, the Commissioner found that a LMC did not provide basic midwifery care and assessment which led to"*a cascade of serious complicated events that in all probability could have been avoided*". Among other things, the LMC failed to communicate adequately with the woman and, as a result, failed in her"*responsibility to obtain an accurate clinical picture*". The Commissioner also found that even if the LMC's understanding of the clinical picture had been correct, she inappropriately sent the woman to a maternity unit rather than hospital, that her assessments at the unit were inadequate, and that she should not have directed the ambulance to return to the unit when the woman started to push on route to the hospital. 12HDC01031

Vulnerable Children Act comes into force

The Vulnerable Children Act 2014 received Royal assent on 30 June 2014, and a number of its provisions are now in force.

The Act introduces a number of significant changes for certain key workforces that provide services to children, including health service providers. The most significant change for these organisations will be the new requirements to conduct safety checks on staff. For more information see our earlier legal alert.

Health and safety reforms

The Health and Safety Reform Bill is currently before Parliament. The Select Committee report is due on 13 September 2014. The Government's intention is that the Bill will be passed this year, with the new Health and Safety at Work Act coming into force from 1 April 2015.

The Bill represents a major change to New Zealand's health and safety system. Among other things, the Bill clarifies duty-holders' core responsibilities, and increases worker participation, leaders' responsibilities, the scope for personal liability and penalties for breach. WorkSafe NZ and Buddle Findlay will present on what the reforms will mean in practice at Buddle Findlay's Auckland and Wellington offices on 16 September 2014. Places are limited. To register your interest, please contact employmentteam@buddlefindlay.com.

Coroners Amendment Bill introduced to Parliament

Following its targeted review of the Coroners Act 2006, the Government has introduced the Coroners Amendment Bill which, among other things, seeks to improve the quality, consistency, and timeliness of coronial investigation and decision-making.

If enacted, the Bill will also amend the requirement to report medical-related deaths to the coroner so that it is focused on 'unexpected' deaths, and will remove the requirement for a mandatory inquest into deaths in official care and custody to allow more flexibility, particularly where the death is from natural causes and there are no suspicious circumstances. The Bill also amends the restrictions on the reporting of self-inflicted deaths and follows the Law Commission's recommendations in this regard.

Health (Protection) Amendment Bill

The Health (Protection) Amendment Bill, which was introduced to Parliament on 31 July 2014, would give effect to the Government's decision to improve the range of measures available to protect the public from the harm associated with some infectious diseases and with artificial UV tanning.

Among other things, the Bill makes gonorrhoeal infection, Human Immunodeficiency Virus (HIV) infection, and syphilis notifiable infectious diseases. It also places a duty on persons who may have an infectious disease, or may have been exposed to one, to provide prescribed contact information and provides for a series of incremental options for the management of individuals with significant infectious diseases whose management puts other people at risk of contracting a disease (this includes empowering a District Court to make a public health order requiring compulsory treatment if, short of detaining the individual indefinitely, treatment is the only effective means of managing the public health risk posed by the individual).

Privacy law reform

The Government has outlined its proposals for reform of the Privacy Act 1993.

The proposed reforms include: a new compulsory requirement to report data breaches to the Privacy Commissioner and notify the individuals affected by the breach in some circumstances; increased fines that apply to offences under the Act; increased obligations when information is transferred overseas; and enhanced powers for the Commissioner, including the ability to issue compliance notices which will be enforced by the Human Rights Review Tribunal. The Government has indicated that it will undertake a "*targeted technical consultation on details of the proposals*" before introducing a Bill to Parliament. Click here for more information.

Extended prescribing rights under Misuse of Drugs Regulations

Amendments to the Misuse of Drugs Regulations 1977 came into effect on 1 July this year, and extend prescribing rights for nurse practitioners and midwives.

Nurse practitioners are now able to prescribe, supply and administer controlled drugs, and midwives are able to prescribe, supply and administer certain controlled drugs listed in a new Schedule 1C (with both groups remaining subject to certain restrictions which apply to any prescriber). In addition, prescriptions for Class A and Class B controlled drugs, and specified Class C controlled drugs may be on a handwritten form or an approved electronically generated form. Click here for a copy of the Regulations (as amended).

New privacy guidance on data breaches

The Privacy Commissioner has released new guidance on data breaches.

The guidance includes suggestions for preventing common mistakes that lead to unauthorised or accidental access to or disclosure of personal information, and advice on what to do when a breach happens. Click here to access the guidance.

New guidance on advance care planning

The National Ethics Advisory Committee (NEAC) has issued a new guidance document on ethical issues in advance care planning.

The guidance is primarily aimed at health professionals, and includes case studies with practical solutions for resolving ethical issues. The guidance can be accessed here.

Report on Enduring Power of Attorney (EPOA) review

The Senior Citizens Minister has completed her review of the 2007 changes to the Protection of Personal and Property Rights Act 1988.

The review identified that changes that are needed to improve the effectiveness of the EPOA provisions and to encourage more people to set up EPOAs. In order to address these issues, legislative change and an information campaign are recommended. The report can be accessed here

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Resource to help whanau prevent suicide

The Mental Health Foundation has released a new guidance document titled "*Tihei Mauri Ora – Supporting whanau through suicidal distress*".

The resource is intended to help whanau and friends to support someone who is in crisis, and provides information about warning signs to look out for, how to handle a crisis, and ways to support loved ones struggling with suicidal thoughts and feelings. The guidance document can be accessed here.

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 - 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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