BUDDLE FINDLAY

Legal update on health law - September 2013

Alastair Hercus, Peter Chemis, Hamish Kynaston, Alastair Sherriff, Natasha Wilson, Catherine Miller

23 September 2013

Employment Court addresses preliminary legal questions in aged-care workers' equal pay claim

The Employment Court has issued a preliminary decision in a landmark equal pay claim brought by the Service and Food Workers Union on behalf of a group of female aged-care caregivers. The caregivers claim that their employer is in breach of the Equal Pay Act 1972 because they are being paid a lower rate than would be the case if caregiving of the aged was not so substantially dominated by female workers. The preliminary decision addressed legal questions about the Act.

There were essentially two key issues at the preliminary hearing. First, in circumstances where a workforce is substantially female dominated, what should the Court use as a comparator group to determine whether there is equal pay? Second, does section 9 of the Act require the parties to be in a live negotiation before a claim can be raised? With regard to the comparator group, the Court rejected the employer's claim that the appropriate comparator group was male caregivers employed in the same sector on the basis that comparing within this group would not eliminate the overall effects of systemic gender discrimination. The Court emphasised that the comparator group had to be one that was free from any gender bias affecting pay rates and had to be determined: "*by reference to what men would be paid to do the same work abstracting from skills, responsibility, conditions and degrees of effort, as well as from any systemic undervaluation of the work derived from current or historical gender discrimination....*". With regard to section 9, the Court determined that the parties did not have to be in a live negotiation in order to raise a claim. The employer has confirmed that it is appealing the decision to the Court of Appeal. *Service and Food Workers Union Nga Ringa Tota Inc v Terranova Homes and Care Ltd* [2013] NZEmpC 157

Rest home successful in removing executor from deceased resident's estate

At the time of his death, Mr G owed a rest home $51,759. Following his executor's refusal to acknowledge or pay the debt, the rest home sought an order removing the executor from Mr G's estate on the grounds of conflict of interest and hostility.

The High Court noted that executors have a duty to pay valid debts owing to third parties, and that an independent and impartial mind must be applied when assessing whether a debt is validly claimed. The Court found that the executor had strongly held views about the impact of the rest home's care on his father, believing it was causative of his death (the Court accepted that these views were honestly held but noted that they were not presently substantiated in any meaningful way). The executor also had financial interests to protect; both as sole beneficiary of the estate, and as the trustee (and beneficiary) of a Trust from which money would have to be recovered to pay the rest home. In these circumstances, the Court agreed with the rest home that an independent executor was required to administer Mr G's estate, and made orders removing the executor and appointing an independent senior lawyer in his place. *Bupa Care Services NZ Ltd v Gillibrand* [2013] NZHC 2086

High Court appoints clinicians to consent to child's blood transfusions

The High Court has placed a 10 month old, Miss A, into the guardianship of the Court and appointed three of her treating clinicians as agents of the Court for the purpose of consenting to blood and blood product transfusions after her Jehovah's Witness parents indicated that they were unable to consent to such transfusions.

Miss A had recently been diagnosed with neuroblastoma and wide spread metastatic disease. Her parents had consented to chemotherapy, and would likely consent to surgery required to remove the tumour. However, because of their religious beliefs they would not consent to blood or blood product transfusions. Although Miss A had previously received an urgent transfusion under section 37 of the Care of Children Act 2004, the Court noted that "*it would not be appropriate for the hospital to simply rely on section 37 in the longer term for A's treatment because it is known that a transfusion is highly likely to be required in the course of chemotherapy and surgery. The hospital has therefore acted responsibly in bringing the present application*". The Court was satisfied that it was in Miss A's best interests that the orders be made, noting that the orders "*confine, as far as is possible in the*

circumstances, the displacement of the parents' decision making in respect of the care for A. Her parents are able to make decisions in connection with the principal part of A's treatment, namely the chemotherapy and surgery, and their role in respect of all other aspects of A's day to day care remains unaffected". *Auckland DHB v E* [2013] NZHC 2154

Family Court makes order permitting remuneration for a welfare guardian

In a case involving family conflict, the Family Court has appointed an independent social worker as welfare guardian for the subject person and directed that she be paid for her services.

In considering whether there is scope to provide payment for welfare guardians, the Court noted that section 21 of the Protection of Personal and Property Rights Act 1988 only allows welfare guardians to charge "*all expenses reasonably incurred*" and that, unlike the equivalent provision for property managers, it does not expressly state that the Court may make an order permitting remuneration. While Judge Murfitt acknowledged that it is unlikely that "expenses" could be read to include "remuneration", he noted that section 10(4) empowers the Court to "*make such other orders...necessary...to give effect, or better effect to [a] personal order*" and concluded that an order permitting payment of a welfare guardian could be made where it was shown to "*serve the welfare*" and "*best interests*" of the subject person. The Court set out a number of factors relevant to its consideration of whether such an order should be made including the availability, suitability, and capacity of family members; cautioned that the terms of any remuneration must be "*protective of the interests of the subject person, least an unscrupulous welfare guardian take advantage of the right to charge for his/her services*"; and reiterated that orders for payment would be unusual. It held that orders were appropriate in this case as "*M's family members are rent with dissension and conflict about him, and there is a compelling need for an independent appointee, so that decisions are focused on M's wellbeing*". *In the matter of MW*[2013] NZFC 3907

Practitioners must renew their APC on time or face the consequences

The Health Practitioners Disciplinary Tribunal has disciplined four dental technicians and one dental therapist for practising without a current practising certificate (APC), with penalties ranging from $1,000 to $10,500 and orders of censure. These and other recent decisions of the Tribunal highlight the importance of the APC as part of the regulatory regime, the absolute responsibility that practitioners have to ensure that their APC is renewed on time, and the firm approach taken by the Dental Council with regards to "late renewals".

In each of the five cases, the Dental Council had sent a number of reminders to the practitioners using the contact details supplied. Where reminders were not received because of a change in details, the Tribunal noted that the responsibility for, and consequences of not, advising the Dental Council of these changes lay with the practitioner. Further, while reminders where helpful, "*it is the responsibility of every practitioner to ensure that the application is made and the appropriate fees paid in a timely fashion such that the practising certificate is issued before the previous one expires. Otherwise, the responsibility is then on the practitioner not to practise until the renewed certificate is received*". The practitioners were censured, fined, and ordered to contribute to costs. 544/Dth12/229P, 555/Dtech13/232P, 556/Dtech13/233P, 550/Dtech13/243P, and 554/Dtech13/236P.

Tribunal finds that counsellor did not breach the Code of Rights

Following an investigation and a breach opinion by the Health and Disability Commissioner, a woman brought proceedings against her former counsellor alleging that he breached Rights 2, 4(2) and 4(4) of the Code by initiating and continuing a sexual relationship while he was counselling her.

The parties were in conflict over the essential facts; including when the counselling relationship ended, and when the sexual relationship begun. The Tribunal preferred the evidence of the defendant, finding that at the time the sexual relationship began the counselling relationship had been at an end for approximately 18-24 months. The Tribunal concluded that there was no exploitation as any imbalance in power had dissipated and could not be expected to influence the plaintiff's personal decision-making, and that the defendant had not breached any professional or ethical standards. The Tribunal noted that this was a different conclusion to that of the Health and Disability Commissioner, but the statute required it to undertake a fresh (de novo) hearing and it had reached its conclusion "*after an oral hearing (cf "on the papers") at which the defendant has been represented by counsel and given an opportunity not only to challenge the plaintiff by way of cross-examination but also to present himself for examination and to call two other witnesses*". *ABC v XYZ* [2013] NZHRRT 25

Tribunal accepts that medication errors will happen but disciplines nurse for failing to report

While working on a busy ward, a nurse accidentally administered the wrong medications to a patient without the appropriate checks. The nurse soon realised her medication error but did not report it. The patient passed away a few hours later. The nurse did not disclose her error until two days after the patient's death and, following an investigation and breach finding by the Health and Disability Commissioner, the Director of Proceedings laid charges against the nurse in the Health Practitioners Disciplinary Tribunal.

The nurse accepted that the charges of professional misconduct had been fully made out. The Tribunal agreed, and emphasised that while the medication error did itself constitute misconduct, the medication error alone would not have been sufficient to warrant disciplinary sanction: "*the circumstances were such that [the Tribunal] can understand how the mistake occurred*". However, the nurse's failure to make appropriate checks before administering the medications, and her failure to report her error clearly warranted disciplinary sanction. The Tribunal noted that: "*It is essential in the practice of nursing, as any other health profession, that there be full, free and frank disclosure of any error*" and that: "*a clear message needs to be sent to the nursing profession and to the public that nurses should avoid errors, but if there is error of any kind, then the obligation is on the nurse to ensure that all steps are taken as quickly as reasonably possible...*". While the Tribunal was of the view that a 12 month suspension would have been appropriate, it concluded that suspension was unnecessary having regard to the nurse's long term of unemployment and her decision not to seek re-employment as a nurse. The nurse was censured and conditions were placed on any return to practice. The nurse was not fined but was ordered to pay one third of costs. 534/Nur12/227D

Chiropractor's advertisement breached Therapeutic Services Advertising Code

The Complaints Board of the New Zealand Advertising Standards Authority has found that a chiropractor's newspaper advertisement contained a therapeutic claim that the chiropractor was unable to substantiate and, as such, had the potential to mislead customers about the ability to "correct", and therefore treat, spinal pain.

The advertisement stated, in part: "*Do you have back pain?*" and described the benefits of its computerised spinal examination. It also stated: "*at a modern chiropractic office your doctor is committed to using the highest quality research and clinical grade instrumentation available for detecting and correcting spinal problems*" and included two images, one of which was headed "*Scoliosis*". While the Board was satisfied that the computerised spinal examination could detect spinal problems, it disagreed with the chiropractor's view that there was no claim in the advertisement to cure or treat anything. The Board found that the advertisement breached Principles 2, 3, and 3(a) of the Therapeutic Services Advertising Code as the therapeutic claim about the ability of the technology to "correct", and therefore treat, spinal pain, could not be substantiated. It also noted its concern about the inclusion of the word "scoliosis", as this strongly implied that the technology could also treat this condition.
Epsom Chiropractor Newspaper Advertisement [2013] NZASA 294

Insufficient formality and lack of oversight of off-label use of ketamine

A psychiatrist, who held dual appointments at a university and at a DHB, prescribed ketamine for 11 of his patients who suffered from treatment resistant depression. Ketamine is only approved in New Zealand for use as an anaesthetic agent, and it was alleged that the psychiatrist's "off-label" use was part of his research agenda, and patients had not given their consent to participate in research. The Health and Disability Commissioner initiated an investigation after the case was referred to him by the National Health Board.

As part of his investigation, the Commissioner talked with the patients involved and reviewed the consent processes. The Commissioner concluded that patients were provided with sufficient information to make informed decisions about the ketamine. Further, while noting that there are often fine lines between innovative treatment and research, the Commissioner accepted that the psychiatrist's use of ketamine was for the "*primary purpose of treatment*", was not clinical research, and was not an "*experimental procedure*" for the purposes of Right 7(6). However, the psychiatrist was criticised for "*insufficient formality in relation to what was clearly an uncommon approach*". In particular, the Commissioner stated that the psychiatrist should have formally documented the collegial discussions he had about the proposed treatment, and warned the psychiatrist of the "*need to exercise caution in situations where his clinical and research activities may overlap... in a situation such as this, there is a risk that the treatment will be viewed as having being incorporated into, and having formed part of, the research output...*". The Commissioner also criticised the DHB for not having an off-label prescribing policy or any requirement to inform management where a practitioner was proposing to use a medication in a new manner: "*it was suboptimal for [the DHB] to adopt a "hands off" system of oversight*". 11HDC01072

DHB vicariously liable for audiologist's sub-standard care

The Office of the Health and Disability Commissioner has published two decisions relating to the care provided by an audiologist at a DHB. In both cases, the audiologist conducted repeat examinations and hearing tests but failed to identify significant hearing

loss.

The Deputy Commissioner found that the audiologist failed to provide a reasonable standard of care and failed to keep accurate and complete records, in breach of Rights 4(1) and 4(2) of the Code. Among other things, the audiologist failed to perform cross-checks and failed to arrange adequate follow up. The Deputy Commissioner also noted that the audiologist had a sole charge position at the DHB since 1989 but had not been a full member of the New Zealand Audiological Society for any of this time, and that the audiologist's facilities and equipment were "suboptimal" and in need of upgrading. The DHB was found to be vicariously liable as it "*failed to ensure that [the audiologist] was appropriately supervised, and failed to provide peer support or checks on his performance. [The audiologist] was working as a sole charge audiologist, in a department with suboptimal facilities and equipment. In these circumstances, [the DHB] did not take reasonable steps to prevent [the audiologist's] breach of the Code*". 12HDC00446 and 11HDC00846

Employer found in breach of Code after home-based caregiver enters into relationship with client

The Health and Disability Commissioner has found a Trust in breach of the Code for failing to adequately supervise, train and support one of its home-based caregivers, and for failing to take appropriate action when it became aware of a personal relationship that had developed between the caregiver and client.

The Commissioner's investigation was precipitated by a complaint from the client's sister after his death. However, the Commissioner found that there was no evidence that the caregiver failed to provide adequate disability services to the client or that she exploited or coerced him. Further, while noting that in many cases it would be ethically inappropriate for such a relationship to exist, the Commissioner accepted that the caregiver had received no training about boundary issues, was not aware that her relationship was potentially unethical, and had advised staff at the Trust and other health providers about the relationship. The Trust was found in breach of the Code for failing to adequately supervise and train the caregiver, and for failing to take appropriate steps once it was aware of the personal relationship that had developed. For example, the Commissioner found that the Trust should have acted more proactively to ensure that the client was receiving safe and adequate care. The Commissioner also found that the caregiver's employment conditions had the potential to compromise both the caregiver's wellbeing and the client's safety, and that it should have provided more support and assistance to the caregiver. 11HDC01045

Disability carer and DHB referred to the Director of Proceedings

Following an investigation into the care provided to a young man with Down Syndrome and Autism at a community home, the Health and Disability Commissioner has referred one of the carers and the DHB to the Director of Proceedings for the purpose of deciding whether proceedings should be taken.

The Commissioner concluded that there was strong and compelling evidence that the carer physically and verbally abused the man, was aggressive when administering medication, and administered medication over and above that which was charted. Other behaviours of concern included allegations that the carer excluded the man's parents (and legal guardians) from his care, and fostered a culture of secrecy by telling staff "*everything that happens in the house, stays in the house*". With regards to the DHB, the Commissioner noted that all DHBs have clear responsibilities to provide safe, quality services; concerns about an employee's competence or conduct must be responded to in a decisive and timely manner; and "*patient safety must be the paramount consideration*". Here, the Commissioner found that the DHB failed to take appropriate action when concerns were raised, and that its poor response, including warning staff about making false allegations, led to the man being unnecessarily exposed to harm for an inexcusable period of time. Further, when concerns were again formally raised, the DHB undertook a paper-based review, and did not interview the man's parents or staff involved in his care: "*it is difficult to justify a decision to conduct only a paper-based review in response to serious allegations of abuse of a vulnerable consumer... evidence supporting [the] concerns would have been available from staff if they had been interviewed... and supported to raise their concerns*". The Commissioner also found that the DHB failed to provide the man's parents with adequate information, including information about the concerns raised and the DHB's response. 11HDC00877

Vulnerable Children Bill

The Vulnerable Children Bill, which was introduced to Parliament on 2 September 2013, has passed its first reading, and has been referred to the Social Services Select Committee. Public submissions on the Bill are due by 30 October 2013.

The Bill follows on from the Government's *White Paper for Vulnerable Children* and the *Children's Action Plan*. If enacted, the Bill would (among other things) require DHBs to adopt and report on child protection policies, and would require DHBs to ensure that contracted providers of children's services also adopt and review child protection policies. The Bill also provides for new standard

safety checks for employees in the Government or in Government-funded children's workforces (which includes health), and a restriction on the employment of persons with disqualifying convictions. Click here for more information on how to make a submission.

Full rest home audit reports available online

From November, the Ministry of Health will trial a new system whereby full rest home audit reports will be available online in addition to the audit summaries that are already available.

According to a press release by Associate Health Minister Jo Goodhew, "*other changes to the website will allow people to see if a rest home has any current problems and what's being done to fix them. Historical audit summaries going back to 2009 will also be published so people can see what progress has been made and if there are any ongoing issues*".

New Deputy Health and Disability Commissioner

Ms Rose Wall has been appointed as a Deputy Health and Disability Commissioner, and began her five year term on 26 August 2013.

Auckland

188 Quay Street
Auckland 1010

PO Box 1433
Auckland 1140
New Zealand

P: +64 9 358 2555
F: +64 9 358 2055

Wellington

Aon Centre
1 Willis Street
Wellington 6011

PO Box 2694
Wellington 6140
New Zealand

P: +64 4 499 4242
F: +64 4 499 4141

Christchurch

83 Victoria Street
Christchurch 8013

PO Box 322
Christchurch 8140
New Zealand

P: +64 3 379 1747
F: +64 3 379 5659