BUDDLE FINDLAY

Legal update on health law - July 2013

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DHB's smoking ban upheld by High Court

The High Court has dismissed a challenge to Waitemata DHB's policy prohibiting smoking in its hospitals and surrounding grounds, including in the in-patient psychiatric ward.

The Court noted that a DHB, like any property owner, can regulate the behaviour and activity of patients, staff and visitors who use and access sites owned or leased by the DHB, so long as any restrictions are consistent with the DHB's powers and functions. Smoking is a recognised and preventable health hazard, and the Court found that the "*containment and reduction of that hazard... falls entirely within the purposes of DHBs to "improve, promote and protect the health of New Zealanders*"". Further, while the Smoke-free Environments Act 1990 allows employers to create dedicated smoking rooms in hospital care institutions, residential disability care institution and rest homes, the DHB was entitled to determine whether it should provide such a place. The Court also found that the policy did not constitute unlawful discrimination as nicotine dependence from smoking is not a disability and the policy treated all patients alike: "*All patients are prevented from smoking if they cannot leave the WDHB's premises. The reason that someone cannot smoke on WDHB's grounds is not because someone is a patient or a visitor, or because they are an employee, or any prohibited ground: it is simply because they are on hospital grounds*". *B & Ors v Waitemata DHB* [2013] NZHC 1702

Court quashes requirement for counselling on boundary issues

The Medical Council's decision that a doctor should be counselled on doctor/patient boundary issues, as recommended by a Professional Conduct Committee (PCC), has been quashed by the High Court.

In this case, the doctor had not been the complainant's treating doctor, but had interacted with the complainant in her professional capacity on three occasions, including calming the complainant following a scan procedure and taking a blood sample when the complainant's usual treatment team was not available. The doctor later entered into an intimate relationship with the complainant's partner (whom the doctor had known for some years). A PCC in vestigated and concluded that the doctor had breached Council guidelines and *"the underlying principle of trust in the doctor patient relationship"*. The PCC's recommendation that the doctor be counselled on boundary issues was accepted by the Council. The doctor successfully challenged this decision by way of judicial review, with the High Court finding that the Council's decision was unreasonable. The Court also found that the reasons provided were inadequate as they did not enable the doctor (or the Court) to understand the basis on which the decision was made, and that the Council ought to have recognised a *"case-specific"* obligation to hear the doctor prior to making its decision (the doctor's request to be heard had been declined in accordance with the Council's usual practises). *C v The Medical Council of New Zealand* [2013] NZHC 825

Subject person must have lawyer appointed before orders can be made under the PPPR Act

The Family Court has recently considered the issue of whether ex parte (without notice) applications can be granted under the Protection of Personal and Property Rights Act 1988 (PPPR). Having examined the requirements of the Family Court Rules 2002 and the PPPR, Judge Burns determined that the Court does not have jurisdiction to hear ex parte applications for welfare guardian orders, personal orders or property orders under the PPPR.

The Judge noted that while there are grounds to dispense with service on the subject person for substantive orders (s63(2) of the PPPR), the legal representative for that person must be provided with a copy of the application (s108(a) of the PPPR). Further, while interim (personal and welfare) orders under Part 2, and temporary orders for the management of property under Part 3 of the PPPR, can be made without the subject person being served, these orders can only be made after a lawyer for the subject person is appointed (a mandatory requirement under s65 of the PPPR) and in a position to be heard: *"[t]here is nothing in the Act*

which prevents an application being dealt with urgently and set down for hearing if necessary in a matter of hours to consider interim or temporary orders but I consider that the Act provides a protection for subject persons by ensuring the appointment of a lawyer. That lawyer's appointment can be dealt with on the basis of urgency". *PT v MJD* [2013] NZFC 2706

Doctor unsuccessfully appeals against 12 month suspension following conviction for child pornography

Following its finding that a doctor's convictions for possession of objectionable material (child pornography) reflected adversely on his fitness to practise, the Health Practitioners Disciplinary Tribunal suspended the doctor for 12 months and imposed a number of conditions. The doctor appealed the penalties arguing the Tribunal made an error about the extent of his culpability and that, in any event, the penalties were unreasonable.

In the affidavit the doctor provided to the Tribunal, the doctor stated that he "*inadvertently downloaded images of the type in question*" and "*categorically*" rejected any inference that he had deliberately accessed child pornography. A more detailed explanation as to the circumstances in which the doctor said he had downloaded the material was set out in a psychologist's report. The Court found that the Tribunal was justified in giving the doctor's "*second hand explanation*" through the psychologist little weight, noting that "*if [the doctor] wanted the Tribunal to take into account significant mitigating features of the facts, then he should have presented this material... in a sworn statement from himself on which... [he] could be challenged*". The evidence of a digital forensic analyst was that the doctor had used search terms associated with child pornography, and the Court agreed with the Tribunal's finding that the doctor had accessed it intentionally. The Court also agreed that a 12 month suspension and the conditions imposed were appropriate. However, it found that the overall financial burden from the combined cost of the rehabilitative programme, the costs award, and the 12 month suspension seemed unfair and disproportionate. Noting that the rehabilitative programme is an important public assurance of safety and should be maintained, the Court reduced the costs award made by the Tribunal from 35% to 5%. *Joseph v Professional Conduct Committee* [2013] NZHC 1131

Midwife was not obliged to disclose her medical condition

A midwife has successfully defended professional misconduct changes brought by the Director of Proceedings which alleged, among other things, that she had an obligation to advise clinical colleagues of a medical condition which could potentially compromise the care she could provide during labour, and that she had an obligation to disclose this to her client.

The midwife had a history of supraventricular tachycardia (SVT) and became unwell during a difficult birth. After the baby was delivered, the midwife felt unable to continue and left the room asking the staff midwife to remain with the family. The Tribunal found that at the time of the incident, the midwife was not obliged to advise her clinical colleagues or disclose her medical condition to her client, noting that: "*[the midwife] had experienced her SVT on relatively few occasions and over a relatively long period of time. The incidents of SVT that related to her clinical professional experience were from an earlier time... and did not impact on her ability to continue the tasks she was performing or interrupt the care she was providing. She found that she could manage the SVT by using the Valsalva breathing technique*". The Tribunal also noted that: "*[t]he position may now very well be different given what [the midwife] knows about the experience she has had through this whole process*", but that this was not a matter for the Tribunal to decide. The midwife's application for name suppression was dismissed on the basis that the public interest outweighed any personal interests identified by the midwife. *Jan Scherp* 532/Mid12/221D

Nurse disciplined for slapping a patient and failing to report incident

A nurse has been found guilty of professional misconduct for slapping a patient, and for compromising the health and safety of the patient by failing to advise the medical practitioner who assessed the patient following the restraint procedure of the incident and failing to complete an incident form.

The Tribunal concluded that the slap was a reflex action in the context of a restraint, with no element of premeditation. However, it confirmed that: *"[i]t is always wholly inacceptable for any health practitioner to assault a patient, even if there is provocation*". The Tribunal also found that the practitioner failed to take appropriate action following the incident (he did not advise the house surgeon who countersigned the restraint reporting form, document the incident, nor complete an incident form) and that this compromised the health and safety of the patient. The Tribunal noted that, had it not been for the fact that the nurse had been excluded from the workplace but was eventually reinstated, it would have suspended the nurse for six months. Further, given the significant loss of income already suffered by the nurse as a result of the incident, a fine was not considered appropriate. The nurse was censured, ordered to pay costs of $12,000 and had two conditions imposed on his practice. *Kees De Bruin* 533/Nur12/226P

Pattern of "suboptimal behaviour" in the care of a patient

Following an investigation into the care provided to a 79 year old patient with significant co-morbidities who underwent a total knee joint replacement, but died six days later from a cardiac and respiratory attack, the Commissioner has found that a combination of poor documentation and poor communication led to a failure by both the orthopaedic team and the nursing team to fully recognise the patient's deteriorating condition, and that both teams failed to adequately access and use critical information that was available to them.

Among other things, the Commissioner noted that: the orthopaedic team did not alert the nursing team to the patient's co-morbidities and the complexity of managing the balance between the patient's cardiac issue and his renal impairment; the nursing team failed to alert the orthopaedic team to concerns about his urine output; members of both teams failed to read the patient's notes which highlighted concerns; and a number of calculation and recording errors were made on the fluid balance chart. "*In essence there was a pattern of suboptimal behaviour in the care of [the patient]".* The Commissioner concluded that the failures of the nursing and orthopaedic teams were service failures and directly attributable to the DHB, and found the DHB in breach of Rights 4(1), (4) and (5) of the Code. 10HDC00419

Complex case highlights perils associated with promising too much to patients

A recent opinion from the Commissioner highlights the importance of being realistic when discussing care plans, and the importance of ensuring competence is formally assessed when a patient is making serious decisions, such as refusing treatment.

In this case, a patient diagnosed with Huntington's disease made it very clear to her GP that she wanted to remain living at home. The GP initially made home visits, however, when the patient became increasingly reclusive and would not let the GP into the house, the only contact was through a curtain or on the phone. When the patient was eventually institutionalised it became apparent that she had been living in unsanitary conditions for an extended amount of time and could not care for herself. The GP was criticised for failing to adequately explain the realities of Huntington's disease, failing to satisfy herself that the patient was competent to make the decision to refuse services, and for continuing to prescribe for a patient she had not adequately examined. The Commissioner found that the "*opportunistic contacts*" between the GP and the patient did not amount to adequate care and support and were not sufficient for the GP to assume that the patient was still competent to refuse services: "*It was inappropriate for [GP] to continue to assume the patient was OK just because there were no blowflies in the windows or no 'smell of death' coming from the flat*". The Commissioner also found that it was inappropriate for the GP to promise that the patient could continue to live in her own home when the nature of her condition meant that she would eventually be unable to care for herself. 11HDC00647

Inadequate staff induction results in missed opportunity for patient

A DHB has been found in breach of Right 4(1) of the Code for failing to ensure that its on-call physician was informed of its patient transfer process, with the Commissioner noting that: "*this case illustrates the critical importance of adequate staff orientation in ensuring the provision of appropriate care".*

A patient who presented to a rural hospital was diagnosed with a suspected cerebral abscess but was not transferred to the neurological service at the main centre until the next day. The treating physician had recognised that a referral was required, but delayed calling the neurosurgeons until the next morning because he was under the mistaken impression that patients could not be transferred after dark. The Commissioner found that the decision not to consult the neurosurgical service earlier was *"suboptimal*", denied the patient the opportunity to have specialist neurosurgical advice and consideration of transfer, but did not warrant a breach finding. The Commissioner concluded that the DHB's orientation system was inadequate, that it "*must be held responsible for failing to ensure [the physician] was informed about... patient transfer processes*". The Commissioner also criticised the standard documentation, noting that: *"it is essential to a patient's seamless continuity of care that all clinical reviews and decisions are fully documented"*. In light of the overall pattern of suboptimal clinical documentation by multiple staff members, the DHB was also found in breach of Right 4(2) for failing to ensure staff met expected documentation standards. 10HDC01344

New PHO services agreement

A new PHO services agreement that came into force on 1 July 2013 has been described as one of the most significant changes in primary health care since the establishment of PHOs in 2002.

The agreement includes new provisions that will enable DHBs and PHOs to more easily work together in district and/or regional alliances, which is intended to encourage clinically-led service delivery and service integration. Other changes include the introduction of new minimum requirements that must be met by PHOs, and a clarification of requirements relating to the provision

of after-hours services. Buddle Findlay was involved in the preparation of the new agreement, and will release a full health update about the new agreement shortly.

Family care policies – changes to the NZPHD Act

In May 2013, the Government amended the New Zealand Public Health and Disability Act 2000 by inserting new provisions relating to payments to people who care for disabled family members. The relevant provisions are set out in a new Part 4A of the Act, which sets out the circumstances under which the Government will pay family carers.

Part 4A provides that family carers will generally not be paid for the care that they provide, and will be paid only if payment is permitted by a family care policy adopted by the Crown or a DHB, or expressly authorised by an enactment. The Act as amended also provides that no person may complain to the Human Rights Tribunal or bring proceedings on the grounds that Part 4A or a family care policy breaches the person's right to freedom from discrimination under certain provisions of the Human Rights Act 1993, which are affirmed by the New Zealand Bill of Rights Act 1990. The Government has described the amendments as being its solution to the Court of Appeal's decision in Atkinson and others v Ministry of Health, which found that the Ministry's policy of not paying some family carers discriminatory. The Government expects that around 1,600 persons with high and very high needs who are currently being cared for by family members will be entitled to employ a family carer.

Government signals changes to the Coroners Act 2006

Following a targeted review of the Coroners Act 2006, the Government has signalled its intention to amend key provisions to improve coroners' recommendations, improve processes within the coronial system to ensure that they are timely and consistent, and better define which cases need to be reported.

Among other things, the publicly released Cabinet Paper noted that some coroners' recommendations have gone outside the case and evidence at hand, or have proposed wide-ranging review or reform of legislation based on limited evidence and without showing how such reviews or reform would have prevented that particular death. It proposed amendments to the Act to ensure that recommendations are focused on the case and evidence at hand and feedback from interested parties is included during the process. The Cabinet Paper also noted that clarity was needed as to which "*medical-related*" deaths must be reported to the Coroner and suggested that: *"[T]he specific wording of the definition... will be developed in close consultation with relevant health sector agencies*".

Law Commission to review suicide reporting rules

The Law Commission will review the rules governing the media's reporting of suicide.

The Coroners Act 2006 currently restricts the information that can be made public about a self-inflicted death without the authorisation of the coroner. The Beehive's press release notes that "*[m]edia reporting of suicides is a delicate subject, and there are strong views as to the benefits and risks it can carry... The Law Commission is well placed to engage both sides of the debate, consider whether the legal restrictions need clarification, and whether or not relaxing restrictions would be a positive step to helping prevent suicides*". The role of social media in discussing suicides, and the difficulties in enforcing restrictions on social media, will also be included in the review. A report by the Law Commission is due by the end of March 2014.

National prescribing list for New Zealand hospitals

PHARMAC has published the first Hospital Medicines List in response to Government's policy to nationally fund DHB-prescribed medicines and provide access to the same hospital medicines nationwide.

The Hospital Medicines List is similar to the Community Pharmaceutical Schedule that PHARMAC also manages, and sets out the pharmaceuticals that can used in DHB hospitals as well as the access conditions that apply. Further information is available at http://www.pharmac.health.nz/.

Dental Council's Code of Practice on Advertising

The Dental Council has approved a Code of Practice on Advertising, which informs oral health practitioners of the standards of practice that are required of them when advertising oral health services.

Among other things, the Code confirms that oral health practitioners are responsible for the form and content of the advertising of health-related services and products associated with their practice, and must not delegate this responsibility to others. The Code will take effect from 1 November 2013: "*This timeframe is to enable oral health practitioners the opportunity to make any necessary amendments to their advertising to ensure that it is compliant with the Code*".

Safe Practice Guidelines for Youth Mentoring

The New Zealand Youth Mentoring Network has worked with the Ministry to produce Safe Practice Guidelines for Youth Mentoring.

The guidelines have been developed to support providers to ensure their programmes are safe for both young people and volunteer mentors, and include advice to assist programme providers to identify safety-related aspects of their programme that require further development. The guidelines also encourage funders of youth mentoring programmes to use the guidelines to determine the suitability of youth mentoring programmes for sponsorship and other financial assistance.

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