Acknowledgements
I acknowledge with gratitude the valuable insights provided by my colleagues Professor Donald Evans, Associate Professor Charlotte Paul and Dr Andrew Moore.

References

Atkins (2004). Bioethics and Health Law in New Zealand: Law Commentary. *New Zealand Bioethics Journal* 5(1), p.9-

Brady, K. (2003). Ministry of Health. What further progress has been made to implement the recommendations of the national Cervical Screening Inquiry? @ http:/ www.oag.govt.nz accessed 27 January 2004.

Brookbanks, W. (2003). Bioethics and Health Law in New Zealand: Law Commentary, *New Zealand Bioethics Journal* 4(1), pp.5-9.

Coney, S. and Else, A. (1999). *Protecting our future*. Wellington: New Zealand Law Foundation.

Crosthwaite, J. (2003). Bioethics and Health Law in New Zealand: Law Commentary. *New Zealand Bioethics Journal* 4(1), pp.10-13.

Else, A. (1999). Longer term issues: access, truth, openness and contact. In Coney, S, and Else, A. *Protecting our future*. Wellington: New Zealand Law Foundation.

Gillett, G. (2003). Access to GP records concern. *Otago Daily Times*, 24 September.

Government proposals to amend the Human Assisted Reproductive Technology Bill. Questions and Answers. May 2003. Available on www.justice.govt.nz

Herbison, P. (2003). Cervical choice vital: researcher, *Otago Daily Times*, 26 September.

Mahoney, J. (2000).Comments on reproductive ethics and the family. *New Zealand Bioethics Journal* 1(1), pp.11-15.

Nelson, L. (2000). Reproductive ethics and the family. *New Zealand Bioethics Journal* 1(1), pp.4-10.

Otago Daily Times (2003a). Cervical testing reassurance, 23 September.

Otago Daily Times (2003b). Medical access changes opposed, 24 September.

Otago Daily Times (2003c). Cervical choice vital: researcher, 26 September.

Paul, C. (2001). Should the law require doctors to make records available for audit of cervical screening? *New Zealand Journal of Medicine*, 114, pp.499-500.

Voluntary Euthanasia Society. @ www.aucklandves.orcon.net.nz/letter.htm. Accessed 20 January 2004.

---

law commentary

Bill Atkin
Faculty of Law
Victoria University of Wellington

In 2003, there were several significant staging posts in continuing sagas affecting health law. The first to be discussed touches on the delicate line between mental health law and crime. The doctor involved in the release of mental health patient, Mark Burton, who almost immediately killed his mother, was the subject of disciplinary proceedings. Secondly, Parliament passed a controversial new code regulating all the health professions. Based on the Cull Report of 2001, its effectiveness will be tested in the years to come. Thirdly, the slow progress on assisted human reproduction laws advanced with two separate legislative initiatives. With some hesitation, we may predict that an appropriate statutory framework will finally be enacted in 2004.

Mark Burton and Dr Fisher

The case of Mark Burton, who a day after his discharge from the mental health services in Invercargill killed his mother in Queenstown, received a lot of publicity. Burton was found not guilty of murder by reason of insanity. The search for someone to blame for the death switched to the medical personnel in whose care Burton had been placed.[1] Towards the end of the year, the Medical Practitioners Disciplinary Tribunal released its decision on the doctor with responsibility for Burton. It found 17 out of the 27 particulars of the charge against Dr Peter Fisher proven and held him guilty of professional misconduct. The Tribunal held that the situation did not amount to disgraceful conduct in a professional respect

although the doctor's failings when viewed cumulatively came close to this higher category.

Dr Fisher was suspended for six months. In order to practise psychiatry or psychological medicine, Dr Fisher had to participate satisfactorily in a vocational training programme in psychiatry for three years, the maximum period that could be specified under the legislation. Awarded against him were costs of $86,000, which the Tribunal doubted his ability to pay. Dr Fisher's career in New Zealand has effectively been ruined by this episode. Later media reports indicate that since this scenario Dr Fisher lost a job with an English mental health trust over the death of a patient, information that the Tribunal did not indicate knowledge of (*Sunday-Star Times*, 4 January 2004).

Dr Fisher accepted that his record keeping was not good. The Tribunal found it grossly inadequate and constituting professional misconduct. The doctor claimed that his actual care of Burton was of an acceptable standard, a claim that the Tribunal rejected. It found that there were serious shortcomings in evaluating Burton's mental state and Dr Fisher had a myopic view in assessing the risk that Burton posed. There were serious deficiencies in the discharge treatment and management plan and the family had not been involved in planning Burton's discharge.

No one will doubt the need for appropriate accountability of health professionals. However, one is left with one or two questions about the Fisher situation. If Burton had not killed his mother, it is unlikely that anything would have happened. Yet, the Tribunal was careful to point out that there was no causal link between the doctor's errors and Mrs Burton's death. This means that Dr Fisher was not legally accountable for Burton's actions but accountability in a broader sense was sheeted home to him. Although as noted above there has been a later incident in Britain, the doctor does not appear to have had a prior history of malpractice. Indeed the Tribunal noted that its findings related to only one patient but over a period of seven weeks.

In releasing Burton, Dr Fisher was not acting as a specialist. He was a 'MOSS' or medical officer special scale and was to be judged according to the lower standards for a MOSS, not those for consultant psychiatrists. He was not however a novice as he had held this position for most of the time since 1994 and was a psychiatric registrar for three years prior to that. Psychiatry is not always the exact science that is evident elsewhere and the decision to release a mental health patient back into the community requires a delicate judgment call. The layperson can surely understand how easy it is to get this wrong, sadly in this instance with dire consequences.

Dr Fisher was not subject to any oversight requirements and the Tribunal expressly stated that it drew no conclusions on the supervision of his work. When it came to Burton's final and critical discharge there was a meeting where, according to Dr Fisher, all those who attended comprehensively reviewed the situation. Significantly the Tribunal held that the review was inadequate because there was no specialist psychiatrist involved. Dr Fisher, it was held, should have enlisted the assistance of a specialist. The trouble was that Dr Fisher thought that he was up to the job. Also missing from the meeting (because of a change in the time of the meeting) was a key worker from the Community Mental Health Team. This person may have played an important role in Burton's discharge and his monitoring in the community. However, the Tribunal declined to sanction Dr Fisher for the absence of the key worker.

Lurking behind much of the Tribunal's decision is the need for teamwork in handling these kinds of cases. Reading the decision in isolation, it is not clear whether Dr Fisher was picked out of the bunch for censure or whether he was a lone ranger. Likewise it is not clear whether better teamwork or the involvement of a specialist psychiatrist would have actually made a lot of difference. The implication to be drawn from the decision, supported by the Health and Disability Commissioner's earlier report, is that they would have. We may therefore wonder to what extent Dr Fisher was really to blame and to what extent the system.

Health Practitioners Competence Assurance Act

If the circumstances that led to the censure of Dr Fisher were to arise in the future, the case would be dealt with differently, although there is no reason to suppose that the result would be altered. The *Health Practitioners Competence Assurance Act 2003* was passed in September, coming fully into force a year later. The Act, along with its companion piece, the Medicines Amendment Act, was opposed by the National, New Zealand First and ACT parties. At one stage in the parliamentary process there was an unsuccessful opposition attempt to get medical practitioners excluded from the Act, a move that would have seriously undermined the unified nature of the new regime. A

third statute, the Health and Disability Commissioner Amendment Act, received full support in the House.

Modelled on the *Medical Practitioners Act 1995* and picking up a number of the recommendations of the Cull Report (Ministry of Health, 2001; see Peart, 2002), the new Act places all health professions under one umbrella. It continues existing bodies such as the Medical Council and creates Dental, Midwifery, Osteopathic and Pharmacy Councils. Other health professions can be added to the list by Order in Council, acupuncturists, psychotherapists and natural health providers being early contenders. When a complaint is made about a practitioner such as Dr Fisher, the matter will in all cases be filtered through the office of the Health and Disability Commissioner, the so-called one-stop shop. The Commissioner has a wide range of options including referring a practitioner back to the relevant profession for disciplinary action, where the case may end up before a new Health Practitioners Disciplinary Tribunal. The Tribunal includes a panel with representatives of each health profession but a particular charge is heard by five members of the Tribunal, including a legal chair and a layperson.

One of the changes from the regime that has in the past governed the work of the Medical Practitioners Disciplinary Tribunal is that the categories of disgraceful conduct, professional misconduct and conduct unbecoming disappear in favour of professional misconduct, plus some specific findings such as practising without a practising certificate. Professional misconduct may be by reason of an act or omission which amounts to malpractice or negligence or which brings discredit to the profession. The key words 'negligence', 'malpractice' and 'discredit' are not defined, although 'negligence' of course has a long legal history. Will mere negligence be enough to invite disciplinary action?

In the Fisher case, the Medical Practitioners Disciplinary Tribunal reviewed the case law on professional misconduct, accepting that the relevant test was whether the doctor's conduct would reasonably be regarded by colleagues and community representatives as constituting professional misconduct and, if so, whether the departure from the expected standard was significant enough to attract sanction 'for the purposes of protecting the public and/or maintaining professional standards and/or punishing the doctor' (Para 184 of *Re Fisher*). If this is the correct approach, the first question in future will be whether there has been negligence, malpractice or discredit, but then it will have to be separately asked whether this amounts to professional misconduct. The latter is to be judged objectively not only against the standards of the profession but also against those of the community. Arguably the new grounds for discipline are easier for the layperson to comprehend but behind them are questions about exactly how they will be interpreted.

The political opposition to the new regime turned on several key points. First, parties were critical of the concept of scopes of practice. This concept becomes the touchstone for determining which profession a person is to be registered for. As a general rule, a practitioner may not practise outside the relevant scope of practice. Determining scopes of practice is a matter for each profession to do but, if there is a dispute between professions over demarcation lines, then the Minister has a residual power to resolve the matter. The opposition parties thought that the scopes of practice concept was new and untried, lacking intellectual rigour. Drawing the boundary lines could be difficult, with some professions being defined too narrowly. The Government's position was that the concept dated back to the *Physiotherapists Act 1949* and was now being used on a generic basis across the board.

Secondly, there was concern about the increased powers vested in the Minister. Apart from scopes of practice, another significant power is the membership of the authorities which will oversee the various professions. Although the professions can nominate candidates, the ultimate choice is with the Minister.

Herein lies a major philosophical shift from the past. Much to the chagrin of some of the professions, there is a movement away from self-regulation towards greater governmental regulation. This is consistent with the principal purpose of the Act, namely to protect the health and safety of the public. Furthermore, the plea for self-regulation has in many respects already been dowsed with the establishment of the Health and Disability Commissioner and publicly appointed ethics committees.

On the other hand, the desire of professions to 'own' their own governing bodies is understandable. The Greens, who supported the legislation with reservations, endeavoured to get 50% of each authority democratically elected. One remnant of this is a provision that enables regulations to be passed setting up a system whereby some or all of the practitioner

authority members of a particular profession may be elected by the profession. The current government has indicated that it is unlikely to activate this provision.

Thirdly, one of the functions of professional authorities is to set standards of 'cultural competence', along with clinical and ethical competence (Section 118(i)). Neither 'cultural competence' nor indeed 'competence' is defined. Some see the reference to culture as political correctness, but it would be odd if health professionals could ignore cultural attitudes to medical matters. Despite submissions on the point, the Treaty of Waitangi is not itself mentioned in the legislation, the apparent reason being that professional authorities are not Crown entities and therefore not Treaty partners.

Fourthly, concerns have been expressed about the provisions on quality assurance activities. These are activities designed to enable health professionals to assess how well their services have been performed in a context free of retribution and blame. A particular 'activity' can receive official approval, and where this happens, information shared during the activity is to remain confidential. However, confidentiality does not apply to conduct that is already the subject of an official inquiry or where the Minister authorises disclosure of information that may relate to a serious offence (Sections 53 and 61). Allied to these provisions is a new rule permitting a practitioner to dob in another because of a risk of harm to the public, with immunity from civil and disciplinary proceedings so long as there was good faith. The Cull Report had recommended mandatory peer reporting requirements.

The new package of legislation changes the ground rules for pharmacies. Pharmacies may in future be owned by companies but only if one or more pharmacists have a majority shareholding in the company. The Minister can give an exemption from this requirement. A licence will be needed to operate a pharmacy but a pharmacist or a company can run up to five pharmacies.

Assisted Reproduction

In 1994, the Ministerial Committee on Assisted Reproductive Technologies (MCART) released its report to the Minister of Justice and discussed a range of options for dealing with issues surrounding assisted human reproduction (Department of Justice, 1994; the author was one of two members of the committee). In 1996 Dianne Yates, then an opposition Labour MP, introduced the Human Assisted Reproductive Technology Bill and in 1998 the government of the day introduced the more neatly entitled Assisted Human Reproduction Bill. These languished for years until in 2003 a Supplementary Order Paper virtually rewrote the first Bill and the second was subsequently discharged. The Health Select Committee is currently due to report on 8 April 2004.

The changes contained in the SOP have been set out elsewhere (Daniels, 2003). Suffice it to point out one or two key points. When finally passed, the legislation will represent a move away from a largely laissez faire approach to one of moderate regulation. While there will be no licensing requirement as in other jurisdictions, the ethics committee system will have a hitherto lacking element of legal clout because it will be an offence to go ahead with new procedures or research without ethical approval.

Reflecting one of MCART's suggestions, there will also be an overall advisory committee which among other things can issue guidelines and monitor developments. This will allow any potential public concern about controversial issues to be filtered through a careful process rather than being ignored or being the subject of knee-jerk reactions. Where there is real concern about a particular issue, a moratorium for up to three years can be imposed by Order on Council.

The Bill will ban certain specified activities. A good example is cloning for reproductive purposes. Cloning for other purposes, where there is far less likely to be widespread consensus, is not banned but will be subject to the statutory framework. A major part of the Bill establishes an information regime for future cases of donation. This is in line with MCART's thinking.

Since 1987, the status of a donor child has been governed by legislation (*Status of Children Amendment Act 1987*). This means for example that, where there has been donor insemination, the mother's husband or de facto partner is in law the child's father and not the donor. Where the mother is single or in a lesbian relationship, the donor is technically the father but with no legal rights or responsibilities. Despite this, in one case ($P\ v\ K^2$) where there had been an arrangement between the donor plus his gay partner and a lesbian couple who were bringing up the child but where relations had broken down, the High Court nevertheless held that the 'father' could

apply for custody under the *Guardianship Act 1968*. However it was said 'There is an urgent need for legislation in this fraught area and for clear policy decisions' (Para 176).

The Care of Children Bill, which was introduced in 2003, tackles this concern. It will replace the *Guardianship Act 1968* and amend the status of children legislation. One noteworthy change is that, where the birth mother is single or in a lesbian relationship, the donor will no longer be the child's legal father, vacuous though that status may be. In the lesbian situation, the partner will be a legal parent along with the birth mother.[3] Thus, a child may have two legal parents, both being 'mothers'. Where the birth mother is single, there will be no legal father. While it may not sound good for a child to be 'fatherless', this is in fact the reality for many children where paternity has never been established.

Another provision in the Bill addresses the *P v K* situation (Clause 42). If there is an agreement between the parents and donor over contact or the role that the donor might play in the child's upbringing, the agreement is not as such enforceable. However, if everyone consents, they can go to Family Court, which can make an enforceable order reflecting the terms of the agreement. Then, where the parties are in dispute over the operation of the agreement, a party can invite the Court to make an order about the matter.

These changes in the Care of Children Bill will not be universally welcomed in Parliament. It remains to be seen whether they survive the legislative process.

Notes

1 For a discussion of the Health and Disability Commissioner's report into the handling of the Burton case, see Warren Brookbanks (2003).

References

Brookbanks, W. (2003). Bioethics and Health Law in New Zealand: Law Commentary. *New Zealand Bioethics Journal* 4:1 February, p.8.

Clause 167, Care of Children Bill 2003, inserting a new section 17 into the Status of Children Act 1969.

Daniels, K. (2003). Legislation to Address Assisted Human Reproduction in New Zealand: The Human Assisted Reproductive Technology Bill, and Supplementary Order Paper Number 80, *New Zealand Bioethics Journal* 4:3 October, pp. 4-7.

Department of Justice, Tribunals Division (1994). *Assisted Human Reproduction Navigating Our Future*. Wellington: Department of Justice, July.

Ministry of Health (2001). *Review of Processes Concerning Adverse Medical Events [The Cull Report]*. Wellington: Ministry of Health.

Peart, N. (2002). Bioethics and Health Law in New Zealand: Law Commentary. *New Zealand Bioethics Journal* 3:1 February, pp. 14-16.

P v K [2003]. 2 NZLR 787: [2003] NZFLR 489.