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EDITORIAL – *Ian Freckelton SC*

Misplaced hope: Misleading health service practitioner representations and consumer protection

A series of court and tribunal decisions in the course of 2012 in Australia has highlighted the vulnerability of seriously ill patients to overtures and advertising by charismatic health practitioners offering panaceas of unproven efficacy. Drawing upon the findings of the Victorian Court of Appeal in relation to Noel Campbell, the Deputy State Coroner of Western Australia in relation to Helfried Sartori, and the Victorian Civil and Administrative Tribunal in relation to Reza Ghaffurian, it is argued that there is a strong public interest in the capacity for effective early intervention by government in relation to unscrupulous and unethical conduct by health practitioners, whether they are registered or unregistered. For Australia a constructive reform would be nationally consistent legislation to regulate unregistered health practitioners.

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LEGAL ISSUES – *Bernadette McSherry*

Legal capacity under the Convention on the Rights of Persons with Disabilities – Bernadette McSherry

Article 12 of the *United Nations Convention on the Rights of Persons with Disabilities* requires states parties to ensure that persons with disabilities “enjoy legal capacity on an equal basis with others in all aspects of life”. This column explores what is meant by “legal capacity” and its constituent elements of legal standing and legal agency. It outlines recent research on what is meant by “support” to exercise legal capacity and explores the issue of whether mental health and guardianship laws that enable substituted decision-making for those with mental and intellectual impairments contravene Article 12.

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MEDICAL ISSUES – *Danny Sullivan*

A new ball game: The United Nations Convention on the Rights of Ppersons with Disabilities and assumptions in care for people with dementia – Anita Smith and Danny Sullivan

The *United Nations Convention on the Rights of Persons with Disabilities* is a powerful international instrument which imposes significant responsibilities on signatories. This column discusses changes in the definition of legal capacity which will have significant impacts on decision-making related to people with dementia. Various restrictions and limitations on personal freedoms are discussed in light of the Convention. The main focus is on challenges to existing paradigms of substitute decision-making, which are in wide use through a guardianship model. Under Art 12 of the Convention, moves to supported decision-making will result in significant changes in ensuring the rights of people with dementia. There are challenges ahead in implementing supported decision-making schemes, not only due to tension with existing practices and legislation, but also the difficulty of developing and resourcing workable schemes. This is particularly so with advanced dementia, which is acknowledged as a pressing issue for Australia due to effective health care, an ageing population and changing expectations.

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A fair dinkum duty of open disclosure following medical error – *Malcolm Parker*

Supporting patients and families in circumstances where medical error has caused significant harm is said to be governed by the principles of ordinary treatment: honest, open communication, empathy and respect. By and large, harmed patients look for acknowledgment of the events that occurred including errors, acceptance of responsibility, a sincere apology, and assurance that lessons learned will be put to preventive use. Australia's National Open Disclosure Standard purports to respond to these reasonable expectations, yet it advises health care professionals that while they may express regret for what has occurred, they should take care not to state or agree that they, or other health care professionals, or health care organisations, are liable for the harm caused to the patient.

The *National Open Disclosure Standard* is currently being reviewed, and the Consultation Draft of the Australian Open Disclosure Framework appears to move things closer to its stated finding that ethical practice prioritises organisational and individual learning from error, rather than an organisational risk-management approach. However, it remains the case that the sense of apology in the Consultation Draft is one of stating regret, not of accepting responsibility. This dissonance in the Draft Framework wording may represent a continuing disingenuousness on the part of health professionals and their institutions regarding the kind of apologies that patients look for.

Following Berlinger, the current author argues that expressions of regret are not apologies, since an apology presupposes the fault that health professionals are advised they avoid admitting. But honest, open communication surely implies both materially relevant disclosure, which would include acknowledgment of fault where that is known, and a genuine apology, as part of the continuing doctor-patient relationship. To the extent that open disclosure policies and practices fudge complete disclosure, admission of fault and genuine apology, they remain deficient instruments in the respect and beneficence owed patients harmed by health care.

Advice to health care professionals to not admit fault, and implicitly to not apologise genuinely, are motivated by legal liability considerations. There is strong evidence that comprehensive communication, including genuine apology and consistent with the medical ethical principle of veracity, is associated with reduced levels of litigation. State health department Open Disclosure policies and State and Territory civil liability legislation should be reviewed to remove obfuscatory and dissembling language and increase consistency between jurisdictions and between policies and statutes. The *National Open Disclosure Standard* should be revised to encourage and support full disclosure and genuine apology. If these processes fail, statutory reform should be considered.

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MEDICAL LAW REPORTER – *Thomas Faunce*

Civil liberties and the critics of safe vaccination: Australian Vaccination Network Inc v Health Care Complaints Commission [2012] NSWSC 110 – *Tim Vines* and *Thomas Faunce*

Public immunisation programs have, time and again, demonstrated their effectiveness at reducing mortality and morbidity from vaccine-preventable diseases such as measles and pertussis. Governments, health agencies and almost all health practitioners regard vaccines as safe and cost-effective treatments with a low risk profile. Nevertheless, despite, or perhaps because of, their success, immunisation programs and vaccines have increasingly been questioned by various lobby groups, sceptical of the safety of vaccines and the motives of those who administer them. Whereas the reach of these groups would have

once been limited by the cost of postage, the internet has delivered a global audience. The extent to which these anti-vaccination advocates are expected to comply with the ethical and professional standards applied to registered health professionals remains unresolved in Australia. As demonstrated in the case of *Australian Vaccination Network Inc v Health Care Complaints Commission* [2012] NSWSC 110, the ability of professional oversight bodies to regulate the information promoted by these lobby groups is limited by traditional conceptions of the doctor-patient relationship and the clinical setting in which medical advice is delivered. Acknowledging that vaccines, like all medical treatments, involve some level of risk, this article explores the relationship between the state, parents, family, medical professionals and such lobbyists within a human rights framework, suggesting that most public immunisation programs deliver benefits in ‘the best interest of the child’ that, on balance, provide a good result for the civil liberties of Australians. 44

ARTICLES

Levelling the playing field? Sharing of influenza viruses and access to vaccines and other benefits – *Nicole Jefferies*

With the adoption of the Pandemic Influenza Preparedness Framework, including its annexes, by the 64th World Health Assembly, this article investigates the disproportionate burden of risk and benefits between resource-poor countries in the developing South and resource-rich industrialised developed nations of the North in the World Health Organisation’s Standard Material Transfer Agreement (SMTA) for accessing and sharing influenza viruses. It concludes that the countries of the South have a unique opportunity to level the playing field through providing timely and affordable access to life-saving vaccine and meaningful benefit-sharing that will deliver technology and economic development. Importantly, the article also demonstrates that SMTAs are not merely a redirection of existing resources from North to South but offer a solution to the ongoing shortage of pandemic influenza vaccine by enabling the South to access technology necessary for sustainable vaccine production and thus increasing global vaccine capacity. 59

The dollars and sense of restraints and seclusion – *Jeffrey Chan, Janice LeBel and Lynne Webber*

Restraints and seclusion are a common practice in many human service settings despite the increasing evidence questioning their efficacy and appropriateness. There are many detrimental effects on people subject to these practices, such as falls, injury, psychological trauma and even death. In addition to the impact on people being served, there is also a range of negative effects on organisations and the workforce. This article outlines and discusses the costs to organisations in implementing restraints and seclusion, and the economic cost-benefits to be gained in working towards the safe elimination of restraints and seclusion. A brief outline of ethical alternatives to restraints and seclusion is explored. The emerging research evidence suggests that it is possible to achieve the safe elimination of restraints and seclusion in a human service organisation. 73

Are people who claim compensation “cured by a verdict”? A longitudinal study of health outcomes after whiplash – *Natalie M Spearing, Dorte Gyrd-Hansen, Louis H Pobereskin, David S Rowell and Luke B Connelly*

This study examines whether the lure of injury compensation prompts whiplash claimants to overstate their symptoms. Claim settlement is the intervention of interest, as it represents the point at which there is no further incentive to exaggerate symptoms, and neck pain at 24 months is the outcome of interest. Longitudinal data on neck pain scores and timing of claim settlement were regressed, controlling for the effect of time on recovery, to compare outcomes in claimants who had and had not settled their

compensation claims. The results show clearly that removing the financial incentive to over-report symptoms has no effect on self-reported neck pain in a fault-based compensation scheme, and this finding concurs with other studies on this topic. Policy decisions to limit compensation in the belief that claimants systematically misrepresent their health status are not supported empirically. Claimants do not appear to be “cured by a verdict”. 82

Criticisms of African trials fail to withstand scrutiny: Male circumcision does prevent HIV infection – *Richard G Wamai, Brian J Morris, Jake H Waskett, Edward C Green, Joya Banerjee, Robert C Bailey, Jeffrey D Klausner, David C Sokal and Catherine A Hankins*

A recent article in the JLM (Boyle GJ and Hill G, “Sub-Saharan African Randomised Clinical Trials into Male Circumcision and HIV Transmission: Methodological, Ethical and Legal Concerns” (2011) 19 JLM 316) criticises the large randomised controlled trials (RCTs) that scientists, clinicians and policy-makers worldwide have concluded provide compelling evidence in support of voluntary medical male circumcision (VMMC) as an effective HIV prevention strategy. The present article addresses the claims advanced by Boyle and Hill, demonstrating their reliance on outmoded evidence, outlier studies, and flawed statistical analyses. In the current authors’ view, their claims portray misunderstandings of the design, execution and interpretation of findings from RCTs in general and of the epidemiology of HIV transmission in sub-Saharan Africa in particular. At the same time they ignore systematic reviews and meta-analyses using all available data arising from good-quality research studies, including RCTs. Denial of the evidence supporting lack of male circumcision as a major determinant of HIV epidemic patterns in sub-Saharan Africa is unsubstantiated and risks undermining the evidence-based, large-scale roll-out of VMMC for HIV prevention currently underway. The present article highlights the quality, consistency and robustness of the scientific evidence that underpins the public health recommendations, guidance, and tools on VMMC. Millions of HIV infections will be averted in the coming decades as VMMC services scale-up to meet demand, providing direct benefits for heterosexual men and indirect benefits for their female partners. 93

Childhood obesity, parental duties of care and strategies for intervention – *Elise Jane Nolan*

Childhood obesity is an increasingly serious issue which causes significant health problems among children. There are numerous causes of childhood obesity. However, the ultimate responsibility for the problems and costs associated with an obese child should be attributed to that child’s parents. Parents owe a duty of care to their child and, when their child is obese, have arguably breached that duty. However, if parents were required to pay their child damages, this would arguably be problematic and of little utility. Rather, intervention strategies should be implemented which seek to treat and prevent childhood obesity and to address the identified causes of childhood obesity. 124

Reappraising consent: Conducting ethical psychiatric research in Singapore – *Gurpreet Rekhi, Benjamin Capps, Tamra Lysaght and Siow Ann Chong*

Singapore is legally restrictive when it comes to research involving minors. The age of majority is 21 and parental consent is required for participation in medical research. This article explores the age of majority and the issues related to obtaining consent for research in Singapore, focusing on “young adults” (17-21 years), using an example of a translational and clinical research project called the Longitudinal Youth at Risk Study (LYRIKS). It describes the unique legal and social conditions pertaining to the age of majority in Singapore, before presenting an argument for consideration as to whether the age of consent to participate in research should be reviewed. It concludes that rather than

a set of doctrinaire rules for the age of participation in research, there should be an assessment of the kind of tasks that minors can assume themselves in respect to a specific project, and the degree of parental involvement. 152

The regulation of preimplantation genetic diagnosis: Is there anything the United Kingdom can learn from the Australian experience? – Michelle de Souza

The United Kingdom fertility regulator, the Human Fertilisation and Embryology Authority (HFEA), is set to be abolished and its functions transferred to the Care Quality Commission. Together with the *Human Fertilisation and Embryology Act 1990* (UK), the HFEA has played a central role in the regulation of preimplantation genetic diagnosis (PGD) and human leukocyte antigen tissue typing (HLA typing). Australia, on the other hand, does not have a national regulatory body for assisted reproductive technologies, which are instead regulated by a series of national guidelines, State legislation and State regulators. Using PGD and HLA typing as a focal point, this article asks, is there anything the United Kingdom can learn from Australia? 165

The legal status of the fetus in New South Wales – Talat Uppal, A Pickering, K Erasmus, J Pardey and Roy G Beran

The issue of how to define the legal status of the fetus is complex. Three clinical cases with fetal losses following motor vehicle accidents raise important issues regarding the legal status of the unborn child. Legislation was submitted to the New South Wales Parliament in the form of the *Crimes Amendment (Grievous Bodily Harm) Bill 2005* (NSW) but was subsequently repealed. Medical technological advances make the viability of a fetus a shifting standard and encourage the comparison between newborns and late-term fetuses, offer increased fetal health status information and provide greater capacity to maintain the life of babies born prematurely. In view of the sophisticated state of medical care available in New South Wales, the three cases reviewed highlight the discrepancy between the medical recognition of the fetus as a patient and its lack of legal recognition. 178

Avoiding a fate worse than death: An argument for legalising voluntary physician-based euthanasia – Julia Werren, Necef Yuksel and Saxon Smith

The legalisation of voluntary physician-based euthanasia is currently the subject of much political, social and ethical debate and there is evidence in Australia of growing support for its implementation. In addressing many of the issues that surround legalisation, the article looks at some overseas jurisdictions that have legalised euthanasia to determine whether the social, political and ethical concerns prominent in the Australian debate have proved problematic in other jurisdictions. In addition, the article examines the report on the *Dying with Dignity Bill 2009* (Tas) which commented extensively on the issues relating to voluntary physician-based euthanasia. 184

The many cases of XFJ: Suitable to drive a taxi or “killer cabbie”? – Vanessa Taylor and Janette Nankivell

For 10 years, the refugee now known by the pseudonym XFJ attempted to gain accreditation to drive a taxi-cab. After many internal reviews and rejections by the Victorian Taxi Directorate, XFJ appealed to the Victorian Civil and Administrative Tribunal (VCAT). The difficulty for XFJ was that shortly after arriving in Australia, he had killed his estranged wife. The Supreme Court of Victoria subsequently found him not guilty of murder on the grounds of insanity. Since XFJ’s mental health has been stable for many years, much of the legal argument at VCAT and the court cases that followed centred around whether he was “suitable in other respects to provide the service” of driving a taxi, as required by s 169(1)(b)(ii) of the *Transport Act 1983* (Vic). This article

looks at the tension between the expert medical evidence and the concept of “suitable in other respects”, which XFJ’s opponents claimed included the maintenance of public confidence and the meeting of community expectations. 204

BOOK REVIEW

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