Medical Officers of Health: Kakapos who are above the law

Dr. Alistair Humphrey

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When I was asked to talk to the Auckland Medico-Legal Society I was told I would be talking to both lawyers and doctors, a daunting task. My wife, who is a lawyer (and a medico-legal one, at that!) warned me not to use any lawyer jokes in my talk. She said the lawyers won't think they're funny and the rest of you won't think they're jokes.

I am going to talk about a peculiarly legislative kind of doctor, the Medical Officer of Health. There are relatively few of them, and their role is not always well understood. They have powers, but, as you can see from my appearance, they do not wear their underpants on the outside of their trousers. I will try to put these powers in a historical context. I will give some examples of the use or not of coercive powers by Medical Officers of Health, with particular reference to the well publicised case of Christopher Truscott. I will describe why I think some of these coercive powers are above the law and what I personally have done to address this. Finally, I will describe the breadth of our role, which goes beyond the use of health legislation, and why I agree with our law makers that the role of the Medical Officer of Health should not be confined to the history books. I note that some of our law makers are here this evening, in particular Dr. Brendan Gray, who played a key role in writing the Public Health Bill, and whose Masters thesis has been an important source of some material for this talk.

Much of the Medial Officers' of Health day to day business involves the use of a variety of legislation. Some countries, notably the UK, felt that the law was a powerful treatment with far too many side effects to be trusted in the hands of mere doctors, and the role of Medical Officer of Health was abolished in England in 1974, to be replaced by a raft of committees. Indeed, Medical Officers of Health became a threatened species in New Zealand in the 1990s, and there was much discussion in

corridors of power about removing these dinosaurs of the medical profession, who wielded too much power. However, we were not destined to go the way of the dodo, and two very important events have led the law makers to recognise that providing a designated medical officer with powers to act quickly can be very valuable. One was the SARS outbreak in China and Toronto in 2003. The other was the avian pandemic threat, which became a reality with the swine flu pandemic of 2009. Both these events demonstrated the need for regionally appointed officers with medical and legislative skills who can act quickly to prevent the spread of infectious disease.

It seems, therefore, that we are more akin to the kakapo than the dodo. A successful breeding programme means that there are now 123 kakapo in New Zealand from a nadir of about fifty. With only about thirty Medical Officers of Health across the country we are slightly rarer than the kakapo but fortunately our survival is not dependent on breeding, or we would have gone the way of the Yangtze turtle a long time ago[*].

All Medical Officers of Health are, in effect, a sub-specialty of public health medicine. For those of you who are not sure exactly what public health medicine is, Professor Donald Acheson described it as "*the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society"*. Some people have questioned whether public health should acknowledge the "art" in its definition. While evidence based-medicine may drive the best quality care, I am sure there are few, if any, clinicians who would dispute that medicine is an art, at least where bedside manner is concerned. While public health physicians deal with populations and systems, and rarely with individual patients and their symptoms, there is certainly an art in dealing with the media, not to mention politicians, bureaucrats and community meetings. There are other definitions of public health, which I will not bore you with except for one. My friend Mr. Rhett Mason, an orthopaedic surgeon with an orthopod's sense of humour, described public health succinctly as "A modern form of alchemy, in which bullshit is transformed into airline tickets". Having flown up from Christchurch this afternoon, that certainly sets me a challenge this evening.

[*] At the time of writing there are two Yangtze turtles left in the world, one female and one male. Aged 80 and 100 years old respectively, they have had great difficulty conceiving fertile eggs.

The Director General of Health designates Medical Officers of Health under s7A Health Act (1956) from time to time as, in the opinion of the Director-General, are required. Subsection 2 states that "Each such person designated as a Medical Officer of Health shall be a medical practitioner suitably qualified and experienced in public health medicine" - in practice, a vocationally registered public health physician with at least six months experience of the New Zealand health system, though most have had much, much more experience. Some said that my colleague Dr. Mel Brieseman worked for at least one hundred years in the public health system before I joined him earlier this century. While I believe that this may have been a slight exaggeration, I understand that while working in India (presumably some time during the Raj) he actually *delivered* Dr. Lynley Cook. She wasn't a doctor at the time of course, but she now works as a public health physician with Pegasus Health. If only all of us had Mel Brieseman's remarkable capacity building skills, New Zealand's medical workforce problems would be a thing of the past. Mel has retired now - we had to change the locks on the building - and now the Medical Officers of Health for Canterbury are me and Dr. Ramon Pink, (Te Aupouri and Te Rarawa) – him, not me. We like to think of ourselves as the living public health embodiment of Te Tiriti o Waitangi. Most regions have at least one MOH (Auckland, God bless 'em, has eight!).

Now for a brief history of Medical Officers of Health and their powers. New Zealand's first Public Health Act in 1872 dealt predominantly with quarantine and vaccination, and did provide for some coercive powers to be used by the Governor of the colony. Further details were added in the Public Health Act of 1876. In particular, a person suffering from "a dangerous, infectious disease" could be removed to a "suitable place" on application to a magistrate by a doctor. In the Public Health Act of 1900 the position of "District Health Officer" was established, who inherited the coercive powers previously limited to either the Governor, or the courts. Of particular note is that the 1900 legislation dropped the requirement for a court order to isolate someone. This has remained the same in all subsequent legislation right up to the present day, including our current health legislation, the Health Act of 1956, now long overdue for a revision. In late 1918 New Zealand was rapidly and severely affected by the Spanish influenza pandemic, which killed more than 7000

New Zealanders - one percent of the population in a matter of three months. The Health Act 1920 followed a commission of enquiry which investigated the epidemic and concluded that clear lines of authority should be established to deal with infectious disease threats. Medical Officers of Health replaced the old District Health Officers, the Department of Health was established (which many people still think exists) and powers were granted to Medical Officers of Health to requisition property during outbreaks, and prevent people from moving from area to another. These powers were backed up with powers to arrest offending individuals. In addition, infirm or neglected persons could be forcibly removed to an institution on application to a magistrate. This is the precursor to the current section 126 of the Health Act which permits the removal of an "aged, infirm, incurable, or destitute person found to be living in insanitary conditions or without proper care or attention" to a suitable institution. This legislation is used for those stubborn and usually elderly people who, because of an illness and often the loss of a spouse, have slid into squalor. Despite frequent requests from district nurses (who naturally have very high standards of cleanliness) it is *not* used on people who simply choose to live in filth, but for those whose circumstances have sadly changed. I regularly remind the public to wash their hands, but, where necessary, I strongly uphold a person's right not to do the housework for months or even years, as long as they put no-one else at risk. It is surprising how healthy some people can stay under these circumstances. Similarly, I am not able to use the legislation on my daughters whose bedrooms become temples of dirty laundry and other teenage detritus.

The last revision of the Health Act was in 1956 and though there have been some additions since then, most notably the Drinking Water Amendments of 2008, this is still the act with which we have to work. Its replacement will be the Public Health Bill which has been discussed since at least the 1970s and we are currently awaiting its second reading as believers may await the second coming of the messiah. That is, with faith and hope, but without holding our breath. While the swine flu pandemic added some impetus, the world financial crisis has clearly put the brakes on the process, and the bill is now definitely on the backburner.

Part 2a of the Health Act deals with drinking water provisions, which permit a Medical Officer of Health to cease dangerous water supply and require a supplier to

find an alternative. There are other parts of the Act which grant similar, well understood and apparently reasonable powers. However, some powers granted under the Health Act are more extreme. Section 70 deals with the powers of the Medical Officer of Health when a state of emergency is declared. Under such situations his or her power, while not limitless, certainly exceeds that of any other official in their region, including anyone working for Civil Defence. There has been some change to the wording of this act (I am no longer required to close the billiard halls, for example) but essentially the powers remain the same. Medical Officers of Health can close premises, requisition premises or vehicles, prevent people ships and other vehicles from entering or leaving an area, destroy insanitary things, isolate people and ban congregations of people.

I have already mentioned section 126 of the Health Act. Section 79 of the Act is much more controversial in a modern context.

This section states that if "*A Medical Officer of Health has reason to believe or suspect that any person, whether suffering from an infectious disease or not, is likely to cause the spread of any infectious disease, he may make an order for the removal of that person to a hospital or other suitable place where he can be effectively isolated*."

There is no requirement for a Medical Officer of Health to apply to a magistrate for the application of this order. Nor is there any right of appeal or period of review built into the legislation. The legal standard necessary for intervention is remarkably low – The Medical Officer of Health only has "reason to believe" before invoking the order.

Such legislation was clearly designed for infectious diseases which were perceived, in the 1950s to be amenable to treatment, after which someone who had been isolated (if they had not died) could return to their community, presumably after a relatively short period.

It is true that this legislation has been used rarely and where it has been used the Medical Officer of Health has been spared consideration of the human rights aspect

its use by the death or recovery of the person subject to the order. Then, in 1999, the then Medical Officers of Health in Christchurch were alerted to repeated wilful and reckless sexual behaviour by a known HIV-positive male prostitute in Christchurch. A local GP and the AIDS foundation both contacted the Medical Officer of Health and demanded that the man, known as Christopher Truscott, be isolated as a public health risk. Initially the Medical Officer of Health refused, but when the man was convicted of criminal nuisance under the Crimes Act the Medical Officer of Health was forced to act. He invoked section 79 and the man was confined to an expensive property in Merivale, supervised by staff of a local NGO under a contract from the Ministry of Health…..a contract which would cost up to $300,000 a year for the next ten years.

Rehabilitation of Truscott was considered impossible, as psychologists engaged to carry out reviews of him concluded that his unsafe sex behaviour was as a result of an untreatable personality disorder. Moreover, he did not suffer from any mental health illness, though some claimed he was intellectually disabled. Some health professionals in Canterbury District Health Board suggested that Truscott's intellectual disability was secondary to HIV and that therefore his care could not be covered under their existing contract with the Ministry. In any case, they argued, he was not intellectually disabled enough to warrant out patient care, let alone 24-hour supervision by their department. I suspect their reluctance to care for him may also have had to do with the enormous financial cost of taking on such a patient.

A previous use of section 79 on an HIV positive man had ended when the man died, but HIV since the 1990s is no longer the death sentence it was once perceived to be. Truscott has remained healthy since 1999. The use of section 79 in this case thereby became a long life sentence for him, without review and with no ability to appeal.

Article 10 of the United Nations Universal Declaration of Human Rights states "*everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal in the determination of any criminal charge against him*". This is a moot point with respect to S79 because it does not give rise to a course of action under New Zealand law.

Nevertheless, the Crown Law Office was asked when s79 was invoked in 1999 whether such use would infringe the Bill of Rights Act, 1990 which has a number of provisions seemingly at odds with s79 of the Health Act. These include the right to freedom of movement (s18) and the right to liberty (s22). However, section 4 of the Bill of Rights Act prevents the repeal of any other New Zealand legislation where there is inconsistency between it and the Bill of Rights Act. This is despite a UN committee recommending in 1995 that the New Zealand Bill of Rights Act be amended to allow striking down inconsistent legislation.

Section 6 of the Bill of Rights Act, however, could be used to question the manner in which a piece of legislation was invoked. While I believe this would have worked with the original orders, I have made amendments to the order which build in legal, ethical and human rights safeguards.

Another way of challenging the use of s79 could be through a writ of *habeous corpus*. Though the process was updated in New Zealand by the Habeous Corpus Act 2001, as long ago as 1670 Chief Justice Vaughan in England stated as a simple fact that "*The writ of habeous corpus is now the most usual remedy by which a man is restored again to liberty, if he be unlawfully deprived of it*". Another legal challenge to s79 could have come through a judicial review by the High Court. Neither of these challenges has arisen, as the Truscott has always told his lawyers that he is "happy where he is". I will now explain how this came about.

When I inherited this case in 2003, some four years after he had been isolated, I found a man who was regularly absconding, much to the delight of the media. Occasionally he was arrested and convicted of breaching his order and security at his place of residence was increased. Bars were placed on the windows, barbed wire was placed over the fences, alarms were fitted and, tellingly, so called "privileges" were taken away from the man. Clearly he was being treated, to all intents and purposes, like a prisoner.

After discussing the problem with Truscott, his staff and the various health professionals responsible for his care (including his GP and infectious disease physician) I removed all security measures other than direct supervision. He was then

allowed to go anywhere and do almost anything, as long as there is a supervisor with him to ensure that he is not an infectious risk – that is, he does not have unsafe sex. In effect this means he does not have sex at all. Since these measures were taken he has not absconded once. More importantly, I am able to so say, according to the strict wording of s79, that Truscott has been "*effectively*" isolated.

Truscott asked that he could be moved from central Christchurch as he had been tempted by the proximity of Hagley Park toilets where he had previously solicited unprotected sex. This request was granted. He now lives out of town in a property where the only security is a laser beam around the perimeter which, when broken alerts his carers that someone has entered or left the property. This meant I did not have to apply for resource consent to establish a place of detention, as Mr. Truscott is not, in fact, detained. A local man suffering from what I call "*rubor cervaicum",* or red neck syndrome, had attempted to have Truscott removed through council processes, but the local council's lawyer agreed with my assessment of the situation. I also contacted the complainant to reassure him that Truscott was not predatory and that the only chance of him transmitting HIV to the complainant would be if the complainant felt unduly tempted by Truscott's proximity to avail himself of Truscott's services. The complainant and Truscott now live as peaceable neighbours and I have heard nothing more from the complainant.

In addition, I included in the order that it be provided in accordance with the rights and freedoms affirmed and provided for in the New Zealand Bill of Rights Act 1990; and the rights of a patient contained in sections 64 to 74 of the Mental Health (Compulsory Assessment and Treatment) Act 1992, as though Truscott was a patient under that Act. In order to ensure that this could be shown to be happening I also included provision for a District Inspector (as provided for under the Mental Health Act) to carry out a review of his care when requested by anyone.

A psychometric review by New Zealand's most senior forensic psychologist confirmed that the man could not be labelled a psychopath (a term used in previous forensic psychiatric reviews) and that his public health risk was low to moderate. His practice of unsafe sex was principally limited to situations where another man was in control of the situation. The forensic psychologist concluded that Truscott did not

seek out other men purely for carnal gratification. Rather, consorting with men he perceived to be "normal" gave him a sense of normality which he rarely felt in his institutionalised life.

A subsequent review carried out by a district inspector concluded that Truscott was being supervised ethically and in accordance with his human rights, but other legal options may be more appropriate for his care. One was the Intellectual Disability and Compulsory Care (IDCCR) Act 2003. This act, in effect, allows for the diversion of intellectually disabled people who have committed a crime, instead of putting them in prison. Truscott had not committed a crime, so technically he was not eligible for this care. However, he was not so intellectually disabled that he did not realise that he could gain his freedom by throwing a brick through the local police station window. Not withstanding this, I prevailed on Truscott to behave himself. As it turns out, there are a few people cared for under the IDCC&R Act who are known as "civil clients" - intellectually disabled people who might commit a crime, but have not.

The Ministry of Health has therefore agreed to develop a contract to look after Truscott under this Act. He has not absconded for seven years, his risk of having unprotected sex is now low and I am happy to say that we are moving from a supervision paradigm to a care paradigm. He will shortly become a disability case, rather than a public health one. Unfortunately, it may be several years before the Health Act is updated to reflect the changes I made in the s79 orders. In the meantime, Medical Officers of Health continue to come under pressure to isolate HIV positive people who wilfully and recklessly have unprotected sex, especially here in Auckland.

There are many other pieces of legislation, besides the Health Act, which involve the Medical Officer of Health. The Sale of Liquor Act 1989 engages us deeply in licensing bars and hotels. The Prostitution Law Reform Act 2003 allows us to inspect brothels though I am aware of only one (female) Medical Officer of Health who has actually done so. The Litter Act 1979 allows us to determine the rate at which councils empty their litter bins (subject to a $20,000 fine). Occasionally we are asked to permit an unusual cremation under the Cremation regulations 1973 – most recently on a hill in Nelson. The TB Act, Venereal Disease regulations and even the

Hairdressers regulations can all provide us with interruptions in our day. Occasionally there is no legislation to deal with an unusual situation, such as the time I was asked what to do about a pair of human legs which had been left in a garden shed. There was no foul play – a funeral director had been asked to embalm them after a bilateral amputation and then forgot to take them with her when she moved house.

Beyond our legislative role there are at least four other important roles for a Medical Officer of Health.

First, they can provide public health leadership in a district, in emergencies, but also when submitting on resource applications or at coronial inquests.

Secondly, they can provide an independent voice with respect to public health. This is important where elected district health board members may pander to their constituents or even where appointed board members (such as the national health board) may pander to their political leaders.

Thirdly, Medical Officers of Health provide the "human face" of a bureaucracy. This is important from the media's point of view, but a person to talk to can be very important when compulsory powers are used. A good example of this was during the swine flu pandemic when the Medical Officer of Health in our region visited those in quarantine. This did not happen in some parts of the country where people who were quarantined became very upset.

Finally, the Medical Officer of Health through his direct link with the Ministry provides to the community a clear link between local public health activities and international obligations. Examples here include responsibilities under the International Health Regulations or where quarantine is invoked.

The Vinerian Professor of Law at Oxford, Professor A.V Dicey coined the term "The Rule of Law" in 1885. He was adamantly opposed to conferring discretionary powers on officials which, he believed, opened the door on arbitrariness – the antithesis of law. There are some aspects of coercive powers of the Medical Officer of Health

which need to be subject to court order. Until the Public Health Bill is passed, Medical Officers of Health will remain, in some aspects, above the law.

However, recent history has shown that acting quickly, being personally identifiable and providing an alternative voice to health politicians are all qualities which communities value in their Medical Officers of Health. At times the role can be a heavy responsibility and as a consequence we have to work closely and very carefully with our legal colleagues. It is now more than a century since the rule of law was removed from some health legislation and in the case of section 79 the Medical Officer of Health remains judge, jury and jailor. I remain hopeful that some responsibility for the use of our powers will be shifted back to our legal colleagues in the courts in the not too distance future.