Auckland Women’s Health Council Newsletter

December 2024

HDC Decision on Breaches of Informed Consent is Insulting and Disappointing

by Sue Claridge

Informed consent is a basic human right and has its origins in the right to autonomy and bodily control. When we consider the right to informed consent, most people think about consent in terms of sexual conduct, and in the context of medical and healthcare.

Women are disproportionately impacted by breaches of their rights to consent, or to refuse consent, in both contexts.

Since 2017, there has been a lot of publicity and international focus on the right of women to consent or withhold consent to sexual behaviour and activity as a result of the #MeToo movement. Focus on issues of bodily autonomy and bodily control have been further magnified by the repeal of Roe v. Wade in the US, and the banning of abortion for any reason in many US states in the last few years.

The right to make informed decisions in medical and healthcare, and to provide or with hold consent to any given treatment or care, is very closely related to the overall right to bodily autonomy and the right to consent or not to sexual activity, especially as for women much of their healthcare focuses on sexual and reproductive health.

That women bear the brunt of breaches of their rights to consent is symptomatic of a cavalier, misogynistic and patriarchal attitude that remains pervasive in our society and in our health system.

It is not that men do not suffer from sexual harassment, assault and rape. It is not that men don’t have their rights to make informed decisions and provide informed consent in medical care ignored. It’s just that it happens far more often to women. In healthcare, often the most excruciating examples of a failure to comply with informed consent rights occur in women’s health – sexual and reproductive health care – which often involve intimate examinations and procedures.

It is hard to understand how breaches of informed consent rights in medical and healthcare still happen in Aotearoa New Zealand, 36 years on from the Cartwright Inquiry into allegations that women with cervical abnormalities had been experimented upon at National Women’s Hospital, without their knowledge or consent.

It is hard to understand how this still happens in Aotearoa New Zealand 30 years after the establishment of the Health and Disability Commissioner (HDC), and 28 years since the implementation of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. The Code of Rights explicitly sets out the rights of consumers/patients to be fully informed and make an informed choice, and give informed consent regarding health care services, including when participating in teaching or research.

Despite the right of New Zealanders, upheld by law, to be fully informed, to make an informed choice and give informed consent regarding their healthcare and medical treatment, our hospitals and health and medical practitioners repeatedly and persistently carry out procedures and provide treatment without the fully informed consent of patients. In a search of the keywords “informed consent” within the HDC’s published decisions, there are 1,592 search results of which 755 are within hospitals (including private hospitals), Te Whatu Ora/former DHBs, and primary healthcare. These are just complaints where there has been an investigation and a published decision.

Medical students are encouraged by senior medical staff to ignore what they have been taught about informed consent (see below). They then have the gall to claim that they – the senior medical staff, those who are teaching students and overseeing students on their hospital rotations, and supervising not yet fully qualified junior doctors – don’t understand their obligations and that there is insufficient clarity around what informed consent means and how they should be applying that in their work.

Medical Students Experiences with Senior Medical Staff

“I explained the University policy, but he [supervisor] wasn’t concerned…”

“Due to the hierarchy in 4th year often felt unable/unwilling to question seniors even though I was aware the consent process was not followed.”

“I was forced to perform an unconsented DRE [digital rectal examination] examination in theatre while a patient was under general anaesthetic. I objected to this but was coerced into performing it anyway by the urologist.”

“Essentially I felt like the medical school didn’t care when I contacted them about being forced to perform a male DRE under general anaesthetic WITHOUT consent… Even quite senior staff were contacted about this and simply were either unsure or unconcerned with this behaviour. I was essentially brushed off.”

“I felt compelled to not waste further theatre time or challenge the consultant.”

“It appeared the consultant had no intention of asking for consent or explaining to the patient what I was going to do.” (The student refused to undertake the examination when the patient said he would rather not.)

 A male student was told by his supervising clinician in an obstetrics and gynaecology setting that informing the particular patient of the procedure “would take forever to explain to someone that is uneducated.” When he queried whether the clinician could ask for consent for him to be present, “this was not done either with the excuse that the patient would not know what that [consent] was and would say yes anyway.”

Repeatedly, in the HDC annual reports, it is stated that “Informed consent lies at the heart of the Code.” Despite that “it is a theme that continues to present in complaints to HDC.” In the 2018 HDC Annual Report, Commissioner Anthony Hill writes “Over the decades, culture and practice in the sector have improved around informed consent, but it continues to appear as an issue in complaints received by HDC.”

When you consider the actual figures, it is hard to see where the **improvement** in “culture and practice in the sector” is actually occurring.

Which brings us to a recent decision by the current HDC, Morag McDowell, which was published on Monday the 14th of October this year regarding a 2019 complaint by a theatre nurse about multiple and persistent breaches of patients informed consent rights at North Shore Hospital.

Before I get to the background to this complaint and the HDC decision, it is important to make clear that this writer and the Auckland Women’s Health Council place an enormous value on the HDC and the work that she and her staff do.

We understand that the HDC and her staff are dealing with an ever-increasing volume of complaints; complaints have gone up 93% in the last ten years, from 1880 in the year ending June 2015 to 3628 in the year ending June 2024. A similar number of complaints are dealt with through the Advocacy Service every year on top of the complaints dealt with by the HDC.

In the current economic climate, with funding cuts to the public service and the health system in crisis, it is inevitable that complaints will increase even further, with the HDC having to consider evermore complaints with shrinking resources.

“In a time where health and disability services are increasingly under pressure, the need for HDC and the Code to promote and protect the rights of people accessing services remains critical.”

Morag McDowell, Health and Disability Commissioner, 2024

In the context of this ongoing work of the HDC to protect and promote the rights of health consumers, we were extremely surprised and disappointed when the decision on the complaint regarding persistent breaches of patients’ informed consent rights at North Shore Hospital, was that there had been no breach of the Code of Health and Disability Services Consumers’ Rights.

Breaches of Patients’ Informed Consent Rights and a Brave Theatre Nurse

In late 2019, I spoke to a theatre nurse at North Shore Hospital who, at that point, had been trying for six years to get hospital management to address persistent breaches of patients’ rights to provide informed consent. Despite her repeated engagement with hospital management over the issue, the hospital took the attitude that, because they are a teaching hospital, the Code of Rights did not apply to them.

Ali (a pseudonym), the theatre nurse, with the support of the New Zealand Nurses Organisation (NZNO) lodged a complaint with the HDC in 2019.

We have published articles in the *AWHC Newsletter* about the specific situation at North Shore Hospital, and about informed consent issues generally in our teaching hospitals, three times since the beginning of 2020.

Over a considerable period of time, Ali observed numerous instances in which patients’ informed consent rights were being breached. These breaches often involved a teaching situation with medical students and trainee interns in women’s health. Many of the breaches involved intimate examinations and procedures, such as vaginal examinations and gynaecological procedures. Some of these instances were detailed in an article published by *Radio New Zealand* in 2019.

Ali knew very well what the Code of Rights sets out in terms of informed consent, and knew that North Shore being a teaching hospital did not absolve the doctors, trainee doctors or the hospital management of their obligation to uphold patient rights. She repeatedly brought these breaches to the attention of doctors and surgeons in the course of her work, and formally raised her concerns with her charge nurse and unit manager, hospital and Waitematā DHB management, and the then chair of the WDHB Board, all with the support of Kate Weston, who was then the Professional Nurse Advisor with New Zealand Nurses Organisation (NZNO).

Ali ‘blew the whistle’ under the Protected Disclosures Act 2000, yet at work she was increasingly under threat from the senior medical staff with whom she worked. Her position became so tenuous that North Shore Hospital stood her down; her safety at work could not be guaranteed by hospital management and she was being bullied and threatened by the doctors and surgeons she had to work with.

Ultimately, Ali was forced to resign. Without a job and without an income, she couldn’t pay her mortgage and was forced to sell her house, all because she repeatedly spoke up in defence of patients at North Shore Hospital whose rights to informed consent were being breached. The Protected Disclosures Act 2000 designed to provide protection for employees and other workers who report concerns, appeared to offer her little practical protection.

The Complaint to the HDC and the Decision

The 2019 complaint to the HDC concerned the failure of the former WDHB to adhere to informed consent processes, specifically in the context of medical students at North Shore Hospital, a “teaching” hospital where medical students gain clinical experience from their third year of medical training, and in their sixth year are referred to as ‘trainee interns’.

The HDC initiated an investigation and in their decision say that:

“The concerns in the complaint relate to the adequacy of senior medical staff’s supervision of junior medical staff at North Shore Hospital, and patient consent for the involvement of students and trainees in clinical care. [Registered Nurse] A’s position is that a reasonable consumer would expect to be informed about the involvement of a trainee doctor and, more specifically, about the proposed extent and nature of their involvement.”

The more than 40 cases where properly informed consent was not obtained, that were the subject of the complaint, were not detailed in the final decision. However, these cases were in women’s health and maternity services at North Shore Hospital, and often involved intimate examinations or the involvement of patients under general anaesthetic.

Although the HDC was critical of the informed consent processes and procedures at the former WHDB and North Shore Hospital, she stopped short of finding that there was a breach of patient rights under the Code of Rights, despite the fact that, quite clearly, patients were not properly informed, and in many cases did not provide consent for student doctors/medical trainees to be present or involved in their care.

In a media release on the decision, Ms McDowell “found weaknesses in Health NZ Waitematā’s system – including its consent forms – noting the processes minimised student or trainee clinician’s involvement, and didn’t prompt introductions for explanations of the role, involvement or degree of supervision of the trainee. Where verbal discussions may have been held about teaching, they were not adequately documented, she said.”

Ms McDowell rejected Health NZ’s “contention that specific consent was not necessary where teaching was part of “sound care provision”.”

She set out in the key principles section of the Decision that:

* A reasonable consumer undergoing surgery would expect to be told who will be performing their surgery and who will be present, including those who are part of the treatment team and those who are not...
* Consumers undergoing sensitive/intimate examinations should know beforehand who will be involved and what their role will be, including any observers. Explicit consent is required.
* Broad, generic statements that teaching may occur in the environment (for example, ‘This is a teaching hospital’) does not absolve providers from giving consumers, in their particular circumstances, the information they need to make an informed choice, including to participate in teaching.
* In general, consumers must be notified who will be undertaking their procedure, and the roles and responsibilities of those involved, including observers.

Many of the patients whose rights were breached still don’t know what happened to them. Many were under general anaesthesia when intimate examinations were performed by medical students or trainee interns, or those students were involved in their clinical care, without their consent. Yet, because they were simply referred to as Patient O, Patient X, etc. in the HDC report, these women still have no idea what went on or that their care was the subject of a complaint.

These patients will likely never find out, with the HDC having said the “focus of its investigation was on the broader, systemic issues, not on the particular circumstances of individual cases”

The No Breach Decision: a Paradox Given the HDC’s Findings

It is hard to reconcile the criticism that Morag McDowell levelled at Health NZ and the former WDHB in the decision report, and her current and previous comments on informed consent, with her ultimate decision to find that there had been no breach of the Code of Rights.

Has she ‘caved in’ to persistent whining by the WDHB and Health NZ that the Code of Rights lacks clarity, that “a lack of consistent national guidance is partly at fault”?

Not only is the Code of Rights absolutely clear, but in 2015, a consensus statement on medical students and informed consent was jointly prepared by the:

* Faculty of Medical and Health Science of the University of Auckland,
* Faculty of Medical and Health Science of the University of and Otago,
* Chief Medical Officers of District Health Boards,
* New Zealand Medical Students’ Association,
* Medical Council of New Zealand.

The consensus statement discusses the Code of Rights and obligations of practitioners to obtain informed consent, the background to the situations that medical students find themselves in in a teaching environment with real patients. Eighteen principles pertaining to informed consent for the presence of a medical student during the care of patients were set out in some detail and with multiple examples.

It was a statement clarifying expectations for informed consent in the training of medical students in Aotearoa New Zealand today. In other words, there was little room for ambiguity regarding the obligations on medical students and their medical supervisors in obtaining informed consent where students were present or taking part in providing care to a patient.

Not only was this consensus statement issued four years before Ali lodged her complaint with the HDC after years of trying to get the WDHB to properly address issues of informed consent in their teaching hospital, but the consensus statement was jointly prepared by the Chief Medical Officers of the DHBs among others.

How is it possible for the WDHB and Health NZ to claim that “a lack of consistent national guidance is partly at fault”?

For the HDC to give any weight to the claims of lack of clarity is insulting. To claim lack of clarity in the first place is insulting.

It is an insult to those whose rights were breached, and to the intelligence of those of us who understand the Code of Rights and the 2015 Consensus Statement on consent regarding medical students and teaching hospitals.

If someone is intelligent enough to graduate with a medical degree, they are quite intelligent enough to understand both the Code of Rights and the consensus statement, and it is weaponised wilful ignorance to state and act otherwise.

A Missed Opportunity to Really Change Culture and Practice

No matter how critical the HDC has been, and what recommendations she has made in her report on the complaint about the former WDHB and informed consent practices at North Shore Hospital, the failure to find that there has been a breach of the Code of Rights is tantamount to a slap on the wrist with a wet bus ticket.

Informed consent is the centrepiece of the Code of Rights; it is a pillar of health consumers’ interactions with health practitioners and the health system. Informed consent in healthcare is a critical tenet, and any failure to uphold patients’ rights to make an informed decision about their care is an abject failure on the part of not only the systems, but on the individuals involved. As set out very clearly in the Code of Rights (and subsequently – for those who appear to fail to understand plain English – with examples in the 2015 Consensus Statement) informed consent rights apply when a patient is involved in a teaching situation.

In Aotearoa New Zealand the failure of health professionals, in particular, doctors, to comply with their obligations to obtain informed consent from their patients is pervasive and persistent. Over the last 13 years, medical ethicist, Dr Phillipa Malpas, has been involved in research into informed consent in the teaching context and that research has shown that there has been little improvement if any.

Medical students understand their obligations around informed consent but, appallingly, are often coerced, bullied or ignored when they raise the issue of consent with senior medical staff. In an interview with AWHC in 2022, Dr Malpas said:

“Certainly, I think the significant power imbalance between students and their seniors is a factor in why some medical students struggle with speaking up and instead, ‘do what they are told’ – often against the students’ wishes.  Students have stated that they have been belittled and criticised by seniors when they do find the courage to speak up and say ‘no they won’t undertake a sensitive examination on a patient who has not given their consent’… there is a core of doctors who do not respect the patient’s right to be informed about who will be involved in their medical treatment and care (observation or otherwise).”

“In regard to medical students, we cannot expect those who are situated at the bottom of the hierarchal ladder to be the ones changing the attitudes and behaviours of their seniors.”

When the most recent paper was published in 2022, Morag McDowell said she was deeply concerned and very disappointed that the issue is continuing after earlier research published in 2018 highlighted the same problem.

She went on to say that “a lack of clinical and ethical leadership is a system failure.”

“These students have not been supported. Leadership from senior doctors and nurses must be shown in rectifying this.”

 “This requires positive and ethical role modelling, and students must feel empowered to question any examination if a patient has not given informed consent.”

“We must do better on informed consent.”

— Morag McDowell, Health and Disability Commissioner, 2022

But ***IS*** the HDC doing better?

This complaint, and the subsequent investigation, was the perfect opportunity for the HDC to draw a line in the sand and say, “enough is enough”.

There simply must be consequences for medical professionals and their institutions (public or private), and for Health NZ, when they do not do all in their power to uphold the rights of patients.

Culture and practice ***must*** change!

If it is possible for one doctor to properly obtain informed consent for the presence and involvement of student doctors, then surely it must be possible for all doctors to adhere to the Code of Rights and the Consensus Statement?

Are doctors who breach patient rights seriously suggesting that it is too difficult for them to understand the rules or undertake a simple task of obtaining consent from a patient?

Despite all that she has lost – her career, her income, her house, her health – Ali is at peace with her decision to pursue her significant concerns about breaches of informed consent rights. When I spoke to her in 2019 and again in 2022, she told me she would do it all again. She sleeps well at night knowing that what she did was right. She believes it is vital that those who are in a position to do so, should speak up for patients.

I spoke to her again while writing this article.

She is disappointed that the Protected Disclosures (Protection of Whistleblowers) Act 2022 didn’t protect her from the fallout – the harassment and bullying – from her reporting the issue to hospital management and the WDHB, and lodging a complaint with HDC.

Ali is angry and very disappointed in the outcome of the HDC investigation. She is disappointed for the more than 40 women whose rights were breached and who will never know that they were one of the cases included in the complaint. She believes they absolutely have a right to know.

In an interview with Paula Penfold for *Stuff*, Ali explained “the very simple — yet, somehow, apparently difficult for some medical staff to understand — concept of informed consent.”

“For me, informed consent would be knowing who actually is going to be touching me. Who's doing the operation, who's going to be in the room? And if my body is going to be used as something to be taught upon, I want to know.”

College of Nurses executive director Kate Weston told Paula Penfold that “We can’t be losing experienced, highly skilled nurses for these kinds of reasons. [The case] has really taken a toll on her wellbeing, professionally and personally. It really significantly contributed to a premature ending of her nursing career, which is hugely saddening.”

If change is happening, it’s glacially slow!

— Dr Phillipa Malpas

It is time that we, as health consumers, demand that our rights are upheld. We must demand that our right to bodily autonomy is upheld. That our right to be fully informed is upheld. That our right to make an informed decision and provide informed consent is upheld. That our right to say no is upheld.

It is clear that, if we wait for all health professionals and their employers, and Health NZ, to do the right thing and uphold our right to informed consent under the law, we will be waiting a long time.

EVE: **How the Female Body Drove 200 Million Years of Human Evolution by Cat Bohannon**

A book review by Sue Claridge

Reading *EVE* was like sitting down with a good friend every afternoon for a week… or maybe two weeks… and having wonderful conversations. You know the sort of friend – the one with whom you can talk for hours and never run out of things to talk about.

You know the sort of conversation – the sort that leaps off on all sorts of tangents before coming back to what you started talking about; the sort of conversation where you think you already know quite a lot and it turns out to be a fascinating voyage of discovery into both topics that you know lots about and know very little about, but either way it captivates you to the extent that you seem to have lost track of time.

This was how *EVE* was for me.

*EVE* is primarily a science book; one about evolution and biology and anthropology. It starts way, way back; long before the earliest hominids, let alone human beings, began to roam the Earth. But don’t worry if you are not a science-y person. The easy, conversational style is really engaging, accessible and easy to follow. None of the book comes across as lecturing, or like a text book or is complicated. However, it is very much a feminist book. There is no doubt where Cat Bohannon’s social sympathies and politics lie.

(Okay, so maybe she verges on lecturing towards the end where she talks more about the lives that so many women and girls across the globe are forced to live; the oppression, violence, rape, gender pay-gaps, education (or lack of) for girls, sexism that no longer has any biological benefit, and outright misogyny. But it is a vital lecture; one that supports and scaffolds the feminist viewpoint, and makes essential reading for non-feminists who have a mind open enough to see that sexist culture and behaviour is hurting us all.)

Even in the 21st century, almost everything we believe we know about human beings – our biology, our evolution, our culture; what it means to be human – is viewed through a masculine lens. Centuries of medical and anatomical research, anthropology, research into evolution; it is all based around men and their bodies. Women, after all, are just men with some extra bits like breasts and wombs... aren’t they?

Except women aren’t just a softer, fleshier version of men, *sans* penises. What if we (and by we, by and large I mean men), collectively over centuries, have been getting it all wrong? What if our physical and cultural evolution has actually revolved around and been driven by the female body?

*EVE* is a must read for anyone – of any gender – who believes that far too much science, medicine and human history has revolved around the male body for far too long. Cat Bohannon makes an extraordinarily cogent and compelling argument that the evolution of the female body has driven, not only human biological evolution, but our social and cultural evolution as well. We are who we are as humans because of the evolution of the female body.

It feels impossible to write a concise review of this book that does justice to it; that describes how fascinating, how important, how revolutionary it is, and how much most readers will learn from it, and how many puzzle pieces fall into place.

Her basic premise is that how women’s bodies evolved has shaped how we experience our bodies and our lives today. She goes all the way back to 205 million years ago and the first mammals. The use of “Eve” is a proxy for the first female mammal at each stage of this journey through time and evolution and there is more than one Eve.

Bohannon started *EVE* as a sort of user manual for the female mammal… “A no-nonsense, hard hitting, seriously researched (but readable) account of what we are.”

“What it really means biologically to be a woman.”

She wanted to tear down the male norm and put better science in its place.

In her Introduction, Cat writes:

“I hope to provide the latest answers to women's most basic questions about their bodies. As it turns out, those basic questions are producing some truly exciting science: Why do we menstruate? Why do women live longer? Why are we more likely to get Alzheimer's? Why do girls score better at every academic subject than boys until puberty, when suddenly our scores drop through the floor? Is there really such a thing as the "Female Brain"? And why, seriously why, do we have to sweat through our sheets every night when we hit menopause?”

To write the story of “nearly every woman, everywhere, ever” she has looked at each one of nine defining features – milk, womb, perception, legs, tools, brain, voice, menopause and love – and followed them all the way back to their origins. These defining features are represented by seven Eves and their Edens – the places, the habitats and environments in which they lived.

Bohannon includes other players in our more recent evolutionary story; hominids including *Australopithecus afarensis* (3.85-2.95 million years ago), *Australopithecus africanus* (3.3-2.1 million years ago), *Homo heidelbergensis* (790,000-200,000 years ago), and Neanderthals (*Homo neanderthalensis* 400,000-40,000 years ago).

Clearly, the defining features that make us human are not all exclusively female – we all walk on two legs, use language, and use tools. However, the gendered evolution of these attributes and the differences between male and female are fascinating. For example, how men and women differ in visual and audio perception; that women retain their hearing better than men as they age; that women have a more sensitive sense of smell; and that how and when light hits our retinas impact on our fertility in a way that doesn’t impact men.

For me, the most fascinating material is to do with the evolution of human reproduction. The reason that we bleed every month when other mammals do not suffer the leaking away of their precious life blood. The constant battle between the life of the unborn baby and its mother; just how dangerous pregnancy really is. The development of gynaecology and midwifery – if you thought that these were relatively modern concepts arising with the ascendance of modern humans, think again. In fact, Cat Bohannon argues that gynaecology began back in the time of *Homo habilis,* 2.8 to 1.5 million years ago. Gynaecology represents our ancestors’ most important invention, more important than tools and more important than fire. More important than agriculture, the wheel and penicillin. It is the invention that ensured our survival as a species.

The reality is, in Bohannon’s words, *Homo sapiens* suck at reproduction. Pregnancy and childbirth are dangerous, and we give birth to incredibly vulnerable babies. Even today, reproductive complications can kill babies and mothers, or leave babies disabled and/or mothers infertile. Other mammals give birth to babies that are on their feet and running within hours, while the mothers barely break their stride. If a species can’t successfully reproduce it is headed for extinction. The management of pregnancy and birth – effectively the practice of gynaecology – started millions of years ago among our ancient human ancestors.

As I said above, it is not just hard, but near impossible to do justice to this book in a book review without writing pages and pages. Cat Bohannon writes as an accessible scientist, a poet, a novelist. She writes with humour, wit, intelligence, compassion and humanity. She is a feminist in the truest sense. She is an advocate for better science and for more research on women’s bodies and how they work.† She includes a healthy dose of pop culture references, and anecdotes from her own life. About 50% of the main text pages include foot notes of additional information – the tangents that I mentioned earlier. They are easy enough to ignore if you don’t want to interrupt the flow of the book… but why would you? These footnotes are the added-value in a book replete with information you never knew was missing from your life, but without which life was probably smaller, duller, poorer.

*EVE* is a thick book, 612 pages, but don’t let that put you off; 171 pages of that are the comprehensive notes and references, and an index, in addition to the footnotes.

As I finish this review, I feel like I should have read *EVE* for a second time before I started writing\*\*; but I currently have a queue of people waiting for me to finish with my copy so I can lend it to them. I don’t feel like I can keep them waiting any longer. So, just get a copy and read it.

Seventeen Auckland Library branches have *EVE*, but as I write, all are out on loan.

I bought my copy from Unity Books ([ordered online, currently available for $32](https://www.unitybooks.co.nz/products/eve-how-the-female-body-drove-200-million-years-of-human-evolution-1)). You can also get it from Fishpond, The Nile, Paper Plus, and Amazon, among others.

Out of The Fry Pan Into the Fire: The Problem With Vaping

By Sue Claridge

**Recent amendments to the Smokefree Environments and Regulated Products Act 1990 have undermined years of concerted efforts to reduce tobacco smoking and harms from tobacco in Aotearoa New Zealand. The most recent amendments that propose to reduce the harms of vaping do not go anywhere near far enough, and effectively condone vaping as a legitimate adult lifestyle choice despite the known adverse impacts of this alternative to smoking tobacco.**

In 2024, the Coalition Government made changes to the Smokefree Environments and Regulated Products Act 1990. The first of these amendments was enacted in March 2024 after the Government introduced an amendment bill to repeal three parts of the Act – the retail reduction scheme, denicotinisation, and the smokefree generation measures – that had been introduced by the previous Labour Government. These amendments were part of the Government’s 100-Day commitments.

In September, a further amendment bill was introduced to Parliament – the Smokefree Environments and Regulated Products Amendment Bill (No 2) – seeking to better protect young people by strengthening the regulatory framework around vaping, proposing to:

* prohibit the manufacture, sale, supply, and distribution of disposable vaping products,
* increase penalties for unlawful sales of regulated products to minors,
* impose retail visibility restrictions for vaping products,
* include restrictions on the sale of vaping products within certain boundaries of schools, marae, and early childhood centres.

Public submissions on the Bill were sought and respondents had only nine days in which to make submissions. The recommendations of the Health Select Committee were presented in a final report on the 31st of October. The Committee recommended that all amendments be passed, and the Bill was passed at the third reading in the House on the 10th of December.

The Labour and Green party members of the Health Select Committee believed that the bill “does not go far enough in restricting the availability of vapes and risks ongoing harms to young people.” They noted that many submitters’ practical solutions were ruled out of scope for the bill.

The Auckland Women’s Health Council was one of those submitters that believed that the Bill did not go far enough. We argued that while we support moves to restrict access of young people to vaping products and efforts to prevent young people taking up vaping, we have significant concerns that the proposed amendments do not go anywhere near far enough to prevent harm from vaping.

In fact, the bill **perpetuates the idea that vaping is a legitimate safe adult recreational habit.**

**It is not!**

The development of modern vapes or e-cigarettes was originally for the purpose of reducing the harm from tobacco smoking. Pharmacist and inventor, Hon Lik, was the first to register a patent for the modern e-cigarette device. Lik was struggling to quit a two-to-three pack a day smoking habit and didn’t want to end up with lung cancer like his father, a heavy smoker. Despite setting out to find a way to obtain the nicotine hit his body craved, without the harmful effects of smoking tobacco, Hon Lik now both vapes and smokes. He patented the e-cigarette and it was introduced to the Chinese market in 2004, reaching the US by the mid 2000s.

E-cigarettes were introduced to the market in Aoteroa New Zealand in 2006 and were widely promoted as a smoking cessation tool. However, since their introduction, vaping has become increasingly prevalent among New Zealanders including those who have never smoked.

****Vaping IS Harmful!****

While AWHC agree that vaping is less harmful than tobacco smoking, it is still harmful to the health of people who vape.

New Zealand researchers wrote in a *New Zealand Medical Journal* article in 2020 that “E-cigarettes are probably safer than conventional cigarettes, however, there is mounting evidence that they are not without harm and the long-term health impacts are not yet known.” They refuted the widely repeated claim that “e-cigarettes are 95% less harmful to your health than normal cigarettes” stating that this is an “unfounded quantification because the data required to make this quantification are not yet available.”

The World Health Organisation (WHO) say that “alarming evidence on their adverse population health effects is mounting.”

Because vape products contain nicotine, there has been the creation of a new cohort of people addicted to nicotine through recreational vaping (as opposed to smokers and ex-smokers whose nicotine addiction started through smoked tobacco). Nicotine is highly addictive and there is evidence from basic human and animal studies that it adversely affects cardiovascular measures and brain development and functioning. Among non-smokers, there is substantial evidence that vape (e-cigarette) use results in dependence on those products.

The Australian report, *Electronic cigarettes and health outcomes: systematic review of global evidence,* found that the identified risks of vapes include: addiction; intentional and unintentional poisoning; acute nicotine toxicity, including seizures; burns and injuries; lung injury; indoor air pollution; environmental waste and fires; dual use with cigarette smoking; and increased smoking uptake in non-smokers. Less direct evidence indicates adverse effects of vapes on cardiovascular health markers, including blood pressure and heart rate, lung function and adolescent brain development and function.

More recent studies have confirmed that vaping/e-cigarettes is harmful to cardiovascular health, and that “e-cigarettes have similar health consequences as traditional tobacco use, including weakening immunity, infections, dental issues, and increased risk of cardiovascular diseases,” and that “e-cigarettes should be considered as harmful as traditional tobacco smoking.”

A systematic literature review, published in August 2024, found that vapes have complex health impacts, and that while they might be less harmful than traditional cigarettes, evidence shows they still pose significant risks, such as EVALI (e-cigarette or vaping-associated lung injury).

Vaping is a “Gateway” to Smoking

The widespread commercial availability of e-cigarettes/vape products has led to the creation of a new cohort of people addicted to nicotine through recreational vaping. Nicotine is highly addictive, and it adversely affects cardiovascular measures and brain development and functioning. Among non-smokers vape use results in dependence on nicotine.

WHO says that E-cigarettes as consumer products have not been proven to be effective for cessation at the population level. There is evidence that vaping has been an effective tool for assisting ***some*** smokers to quit in Aotearoa New Zealand. Research published in 2022 found that in a retrospective analysis of Te Hā – Waitaha smoking cessation service, in a “vape to quit” cohort “16% were smokefree and vapefree, 31% were smokefree and vaping, 31% were smoking and not vaping, and 22% were smoking and vaping.”

In another recent Aotearoa New Zealand study, researchers found that, while the prevalence of smoking was decreasing, the prevalence of vaping was increasing. They also found that “no differences were observed in the likelihood of transitioning from smoking to vaping or from vaping to smoking, indicating that either pathway was equally as likely.”

The researcher concluded that “vaping appeared to be just as likely to have a gateway effect to smoking as it was to have a cessation effect.”

Young adults, including those over 18, take up vaping not just because they think that it is less harmful than smoking, but because they the messages they get are that it is actually safe.

Despite the increasing volumes of peer reviewed medical research that demonstrates that it is not safe, vaping is increasingly seen as a “cool” thing to do recreationally; it is not seen as a health tool to reduce harm from smoked tobacco and to aid quitting, but as a legitimate adult pastime. There has been a significant rise in the availability of vape products and number of retail outlets selling to people who have never smoked.

Dr Damian Scarf of the University of Otago, and his colleagues write that “there are emerging concerns that vaping may have simply become another addictive behaviour, of which we do not yet understand the long-term effects. Indeed, one recent pro-con review concluded that the potential positive benefits of e-cigarettes are overshadowed by their negative effects in the absence of a confirmed cessation effect.”

They say that “current young adults who smoke tend to be significantly more likely to have used or continue to use an e-cigarette, relative to those who do not smoke.” Ultimately, they concluded that their research emphasises “the need for stricter policies regarding vaping. Contrary to the desired hope, vaping appears to have emerged as just another smoking-related behaviour rather than a substitute for smoking that primarily helps people to quit.”

Amendment Bill a Tragically Missed Opportunity

The World Health Organisation said in their December 2023 *Call To Action* that “it is not recommended that governments permit sale of e-cigarettes as consumer products in pursuit of a cessation objective. Any government pursuing a smoking cessation strategy utilizing e-cigarettes should control the conditions under which the products are accessed to ensure appropriate clinical conditions and regulate the products as medicines (including requiring marketing authorization as medicines).”

In failing to properly consider the evidence, and many submitters’ concerns, about the harms of vaping, the Government has missed a perfect opportunity to properly strengthen regulations around the availability of vape products and therefore protect the health of New Zealanders now and into the future. The Government has also ignored the advice of the WHO.

All the Smokefree Environments and Regulated Products Amendment Bill (No 2) will do is better prevent the sale of vape products to under 18s. Meanwhile, it has effectively said to all other adults, go for it, vape to your heart’s content. They have washed their hands of their responsibility to protect the health of New Zealanders. In doing so, the Government has blatantly pandered to the tobacco industry, whose sole purpose is the manufacture and sale of harmful tobacco products for profit; an industry that has turned to manufacturing and selling vape products to make up for lost revenue from declining sales of tobacco products.

Vaping is harmful at any age and vape products should not be available except as a tool to help tobacco smokers quit. There should be no retail availability of vape products at all. Retailers of vaping products are necessarily driven by a profit model that is predicated on increasing sales, and therefore, increasing both the number of customers and the number of vape products each customer purchases. This is in direct opposition to the concept of reducing tobacco smoking rates and providing the practical tools and support to existing smokers to quit smoking. This concept would see a reduction in uptake in tobacco smoking over time, and therefore, a reduction in the number of vape product customers over time. This is antithetical to the model of retail supply of vape products.

The best option for supply of vape products is through pharmacies to tobacco smokers legitimately trying to quit. Retailing of vape products must be prohibited and vape products must only be available through controlled outlets (in the way that methadone is for opioid addicts) that are not driven by the profit model for the sales of such products.

We currently have legislation – and a Government – that accepts the harmful practice of vaping as a legitimate and okay thing to do, such that we have specialist vapes stores where vape products can be sold to anyone over the age of 18. We might as well allow the sale of other addictive and harmful substances, like methadone, on the basis that it is less harmful than a class C drug like heroin. Or perhaps we could retail pharmaceutical amphetamines because they are less harmful than meth.

Tobacco harm reduction is a key public health strategy, but as a nation we seem to have entirely lost sight of what we were trying to achieve with vape products.

Vaping must not be seen as a legitimate and “safe” recreational habit.

Vape products must only be available to tobacco smokers wanting to quit smoking.

Māori and Pasifika People Most Likely to Vape

**Vaping prevalence and trends: Important findings from 2023-24 NZ Health Survey**

* Daily vaping prevalence among adults aged ≥15 years increased from 3.5% in 2019/20 to 11.1% in 2023/24. This represents an estimated 480,000 people vaping daily in 2023/24.
* Vaping prevalence was particularly high among younger age groups, Māori and Pasifika peoples, and people living in neighbourhoods with higher levels of deprivation.
* Increases in vaping have been greater than decreases in smoking, which has led to a small but statistically significant increase in the prevalence of people smoking daily and/or vaping daily between 2018/19 and 2023/24.
* Daily vaping in the 18-24 year age group increased to 26.5%.
* The next highest prevalence was 16.3% among 25–34-year-olds.
* Among 15–17-year-olds, daily vaping prevalence increased to a peak of 15.4% in 2022/23 and declined to 10.5% in 2023/24.
* Māori were three times more likely to vape than non- Māori and Pasifika peoples were over one and a half times more likely to vape than non-Pasifika. The absolute increase in vaping prevalence among Māori, Pacific peoples, and European/Other has been greater than the absolute reduction in smoking prevalence over this period.
* Daily vaping ranged from 4.8% in quintile 1 (least deprived) to 19.0% in quintile 5 (most deprived); people living in quintile 5 were more than twice as likely to vape daily than people in quintile 1.

There Can Be No Equality Until There is Equity

By Sue Claridge

In his promotion of the Treaty Principles Bill, ACT Party leader and Associate Justice Minister David Seymour has made much of the idea that his Bill will ensure equality among New Zealanders.

However, there cannot be equality without equity.

You can have laws that state that all New Zealanders are equal in before the law, but in practical terms unless there is equity there cannot be true equality, and equity is something that is in short supply in Aotearoa New Zealand, especially for Māori.

If passed and enacted the Bill would set out the principles of the Treaty of Waitangi in legislation, and “to require, where relevant, that those principles must be used when interpreting legislation.”

One of the three Principles defined in the Bill is the:

Right to equality—everyone is equal before the law and is entitled to the equal protection and equal benefit of the law without discrimination. Everyone is entitled to the equal enjoyment of the same fundamental human rights without discrimination.

The purpose of this article is not to debate the political and legal details of the Bill. Auckland Women’s Health Council is an organisation concerned with women’s health. Over the last 36 years we have observed the inequities and disparities for Māori in health, healthcare, and outcomes of care and treatment. We do not believe that a piece of legislation that says all people in Aotearoa New Zealand will be equal will make it so. We do not believe that equality is achievable while inequities between Māori and non-Māori throughout society remain.

No New Zealand legislation specifically refers equality; according to the Human Rights Commission (HRC) the “clearest statement on equality in New Zealand is found in Article 3 of the Treaty of Waitangi, in which the Crown extended to Māori the Queen’s protection and imparted to them ‘all the rights and privileges of British subjects’.”

The HRC say that while closely related, freedom from discrimination and equality are not the same, that “a world without discrimination is not necessarily a world of equality.”

We do have laws that say that people must not be discriminated against on the basis of race and culture.

The principles of non-discrimination and equality are fundamental to human rights law.

— Te Kāhui Tika Tangata | Human Rights Commission

In June 2020, then Minister of Health, David Clark, admitted that institutionalised racism exists in our health system. The previous year, when interviewed for an in-depth story for *Radio New Zealand,* he acknowledged that the health system has been failing Māori for years:

“There is no question that our public health service can and must do better for Māori. We’ve known for decades that Māori have lower life expectancy and suffer higher rates of preventable diseases. And we know that Māori, and other disadvantaged groups, do not always get the same access to treatment as Pākehā. That’s wrong and something we should never tolerate.”

“Māori today are living with the consequences of years of disadvantage. Like all societies, in New Zealand we still see prejudice, unconscious bias and racism – we need to challenge that wherever we see it, including in health.”

Freedom from discrimination is set out in the Human Rights Act 1993 and upheld in the Bill of Rights Act 1990. “In 2009, the Human Rights Commission recommended to the Minister of Justice that an explicit reference to equality in the Human Rights Act and the Bill of Rights Act was now necessary to ensure equal outcomes, not just equal treatment.”

Here we have the crux of the matter: equal treatment does not lead to equal outcomes. Inequities must be addressed before equality is possible. And while we have laws prohibit discrimination on the basis of colour race, and ethnic or national origin, that does not mean discrimination doesn’t happen… including in our public sector, such as in our health system.

There have been myriad reports, medical papers and media articles that set out the issues – from overt racism to widespread deprivation – that plague Māori health. Between 1992 and 2016 alone, there were 107 Ministry of Health reports on Māori health outcomes and disparity in outcomes between Māori and non-Māori. It is hard to see where there has been any improvement in health outcomes for Māori in the last thirty years, despite these 107 (and more since 2016) reports.

The Waitangi Tribunal 2575 inquiry and the Health and Disability System interim report both concluded that the Government had persistently failed to deliver health equity for Māori.

The *Health and Disability System Review – Interim Report, Hauora Manaaki ki Aotearoa Whānui – Pūrongo mō Tēnei Wā* found:

* On average, Māori die seven years earlier than non-Māori and are 2.5 times more likely to die from diseases that can be addressed through health care.
* One-third of Māori preschool children receive no oral care, and more than half of 5-year-old Māori children have dental caries (33% higher than for non-Māori children).
* Young Māori have poorer general physical and mental health, are more overweight, have greater substance use, and higher exposure to violence.
* Hospital admissions for self-harm are higher and suicide rates double among Māori aged 15–24 compared to non-Māori.
* Māori develop diabetes up to 10 years younger and progress earlier to more serious disease, yet are less likely to receive appropriate monitoring and testing.
* Despite being significantly more likely to report multiple disabilities, Māori aged 65 and over are much more likely to have unmet need for a disability aid than non-Māori.

In July 2019, the report *A Window on the Quality of Aotearoa New Zealand’s Health Care 2019 – a view on Māori health equity* was published by the Health Quality & Safety Commission. The report focused on Māori health equity and concluded that there are the following health inequities for Māori:

* Inequity in access: services are less accessible for Māori, with health services being less likely to be accessible for Māori compared with non-Māori over the life course, beginning prior to birth,
* Inequity in quality: services are not providing the same benefits for Māori; even when they can access services, the evidence shows inequity in the quality of those health services and treatments for Māori.
* Improvement – efforts to improve quality do not always improve equity for Māori.
* For years Māori and Pasifika peoples have suffered the impacts of inequities and disparities in health that manifest as greater incidence of ill health, poorer access to health and disability services and significantly poorer health outcomes.

In his foreword to the report, Professor Sir Mason Durie says “It would be misleading to conclude that failures in the health system are the reason for all the disparities. Sub-standard housing, poor education, unemployment, low incomes, cultural alienation, alienation from land, and frank discrimination have all contributed to the problem. In that respect, a whole-of-society remedy must be sought.”

Māori Disadvantage

* 40% of Māori live in the two most deprived deciles, compared to less than 15% of New Zealand European/Pākehā.
* Taitamariki Māori aged under‐25 years have higher rates of hospitalisation for medical conditions than New Zealand European/Pākehā, particularly those from the most deprived (quintile 5) areas. Nearly half of the medical hospitalisations for Māori are potentially avoidable.
* Wāhine Māori are more likely to experience delays in surgery for early breast cancer greater than 31 days in the public health system compared with New Zealand European/Pākehā; deprivation and treatment facility type contributes most to this.
* Māori are almost twice as likely to be living in damp, cold and mouldy homes than New Zealand European/Pākehā, and are significantly less likely to be able to heat their living rooms in winter.
* Māori are consistently more likely to experience overcrowding in their homes; 21% live in a crowded household, compared to 5% of New Zealand European/Pākehā.
* Māori are more than twice as likely as New Zealand European/Pākehā to leave school with no qualification.
* Teachers consistently under-estimated the ability of some groups of students, such as Māori, and Māori students self-report higher levels of discrimination than other students and that much of this discrimination is from teachers rather than fellow students.
* Racial harassment in the workplace was experienced by 52% of Māori in the five years to 2022.
* Differences in wages between Māori and Pākehā can only partly be explained by differences in occupation and qualification levels.
* Rangatahi Māori are significantly more likely than Pākehā youth to have: moved home two or more times in the previous year; reported witnessing family violence at home; experienced sexual abuse; or been in a serious physical fight. They are also more likely to rate their general health as fair or poor, and less likely to see a doctor. When socioeconomics and poverty are factored into the data, these inequities decreased.
* Rangatahi Māori suffer significant inequity in the areas of mental health, substance use, sexual health, and nutrition and physical activity, but again socioeconomic deprivation reduces the magnitude of the inequity.
* More than 25% of rangatahi Māori report experiencing discrimination through health providers.
* Māori suffer more and more serious injuries than non-Māori yet benefit less from ACC coverage. They face barriers to accessing ACC, have fewer claims accepted, are less likely to be referred for certain treatment interventions and have poorer long-term injury outcomes. Wāhine Māori were less likely than tāne Māori to receive weekly compensation for injury. Māori are more likely to suffer ongoing disability as the result of an injury and are more likely to die from an injury. Rangatahi Māori from 15 to 18 years are more likely to die in the 30 days following major trauma than non-Māori. Higher injury risk and poorer outcomes reflect difference in the social determinants of health including racism and the performance of the health system for Māori.

Equality means providing everyone with the same resources regardless of whether everyone needs them. In other words, each person receives an equal share of resources despite what they already have, or don’t have.

Equity is when resources are shared based on what each person needs in order to adequately level the playing field.

David Seymour and the Treaty Principles Bill are sending the message to many New Zealanders that Māori are getting something that non-Māori are not getting. The facts tell an entirely different story. However, those New Zealanders that fear that they are missing out, that Māori are indeed getting “more” than them or are benefiting in some way that is denied non-Māori, think that this Bill is going to make us all equal.

It won’t!

How can we have equality before equity?

How can anyone look at the statistics and suggest that Māori are getting something, have some advantage, that the rest of us do not?

For Māori, health is a taonga (treasure); Te Tiriti o Waitangi ensured tino rangatiratanga (sovereignty) over their taonga. What has happened to this taonga in the 184 years since the signing of Te Tiriti?

Ko te Kuini o Ingarani ka wakarite ka wakaae ki nga Rangatira ki nga hapu – ki nga tangata katoa o Nu Tirani te tino rangatiratanga o o ratou wenua o ratou kainga me o ratou taonga katoa.

The Queen of England agrees to protect the Chiefs, the subtribes and all the people of New Zealand in the unqualified exercise of their chieftainship over their lands, villages and all their treasures.

— Te Tiriti o Waitangi

We cannot fix what ails us as a nation by asserting in a piece of legislation that all New Zealanders are equal before the law. We must accept and understand that 184 years of colonisation – and concomitant intergenerational trauma, and interpersonal and structural racism – has led to significant inequities and disparities for Māori. We must deliver equity for Māori. We must, as a matter of urgency deliver health equity for Māori, and accept that this must be done, at least in part, by indigenising healthcare for Māori.

Sadly, health is but one example of the inequities Māori suffer.

Bishop Manuhuia Bennett described Te Tiriti as ‘the promise of two peoples to take the best possible care of each other’.

That promise has been broken, over and over again.

For all New Zealanders to be truly equal, we must as a nation address the many disparities and inequities that Māori are impacted by. Only when we have equity can we be equal.

For when Māori thrive, we all will thrive.