IN THE EMPLOYMENT RELATIONS AUTHORITY
WELLINGTON

Determination Number: WA 98/07
File Number: 5073213

	BETWEEN	The Association Of Professionals & Executive Employees Inc Applicant
	AND	Capital & Coast District Health Board Respondent

Member of Authority:	G J Wood
Representatives:	Bill Manning for Applicant Jonathan Coates for Respondent
Investigation Meeting:	19 and 20 June 2007 at Wellington
Further Information:	1 July 2007
Determination:	17 July 2007

DETERMINATION OF THE AUTHORITY

Employment Relationship Problem

[1] The applicant (APEX or the Union) has first claimed that the respondent (Capital & Coast or the DHB) made a request for life preserving services during strike action that could not reasonably be considered to meet the agreed criteria. Second, it claims that once challenged by the Union, the DHB failed to act in good faith by not fully informing the union of events and keeping it out of the DHB's internal review. At the conclusion of the first day of the investigation meeting, APEX withdrew its first claim.

[2] Capital & Coast denied any of its actions in responding to APEX's challenge to its request for life preserving services amounted to a breach of good faith.

The Facts

[3] APEX is the union that represents many radiation therapists in public hospitals, including Capital & Coast. Radiation therapists provide radiation treatment for patients, many of whom have

cancer. APEX's national secretary is Dr Deborah Powell, an experienced industrial relations practitioner and a qualified medical doctor, albeit that she has not worked in a hospital since her first year as a Registrar more than a decade ago.

[4] In February 2006, the Union initiated bargaining for a collective agreement for employees substantially employed as radiation therapists at Capital & Coast and five other DHBs. After months of negotiation and industrial action, APEX issued strike notices against Capital & Coast on 29 September. The strikes were to involve a complete withdrawal of union labour between 4.40pm and 8am each day (plus the whole of the weekend) for the period 16-23 October.

[5] The parties are bound by the Code of Good Faith for Public Health Sector, which is set out in Schedule 1B to the Employment Relations Act. The purpose of the Code is as follows:

> *"…*
>
> *(a) to promote productive employment relationships in the public health sector:*
>
> *(b) to require the parties to make or continue a commitment –*
>
> *(i) to develop, maintain and provide high quality public health services; and*
>
> *(ii) to the safety of patients; and*
>
> *(iii) to engage constructively and participate fully and effectively in all aspects of their employment relationships:*
>
> *(c) to recognise the importance of –*
>
> *(i) collective arrangements; and*
>
> *(ii) the role of unions in the public health sector."*

[6] Clearly the purpose of the Code is multi-faceted. Important considerations are the commitment required of the parties to the safety of patients and the importance of collective arrangements and the role of unions.

[7] Clause 4 of the Code deals with the general requirements of the parties as set out below:

> *"4. **General requirements***
>
> *(1) In all aspects of their employment relationship, the parties must –*
>
> *(a) engage constructively; and*
>
> *(b) participate fully and effectively.*
>
> *(2) In their employment relationship, the parties must –*
>
> *(a) behave openly and with courtesy and respect towards each other; and*
>
> *(b) create and maintain open, effective, and clear lines of communication, including providing information in a timely manner; and*
>
> *(c) recognise the role of health professionals as advocates for patients; and*
>
> *(d) make time to meet as and when required –*

(i) to address not only the industrial issues between the parties but also issues facing the public health sector, the employer and the employees; and

(ii) to search for solutions that will result in productive employment relationships and the enhanced delivery of services; and

(iii) to ensure that any change is managed effectively; and

(e) recognise the time and resource constraints that may affect their ability to participate fully, and make allowances for those constraints.

(3) To enable employees and their unions to comply with subclause (1), employers must ensure that appropriate steps are taken in their workplaces to encourage, enable, and facilitate employee and union involvement.

(4) The parties must use their best endeavours to resolve, in a constructive manner, any differences between them.

(5) Subclauses (2) to (4) do not limit subclause (1)."

[8] The general requirements clearly require the parties to communicate openly and effectively.

[9] Clauses 11 to 13 deal with patient safety. They provide as follows:

*"11. **General obligation for employers to provide for patient safety during industrial action***

During industrial action, employers must provide for patient safety by ensuring that life preserving services are available to prevent a serious threat to life or permanent disability.

*12. **Contingency plans***

(1) A soon as notice of industrial action is received or given, an employer must develop (if it has not already done so) a contingency plan and take all reasonable and practicable steps to ensure that it can provide life preserving services if industrial action occurs.

(2) If an employer believes that it cannot arrange to deliver any life preserving service during industrial action without the assistance of members of the union, the employer must make a request to the union seeking the union's and its members' agreement to maintain or to assist in maintaining life preserving services.

(3) The request must include specific details about –

(a) the life preserving service the employer seeks assistance to maintain; and

(b) the employer's contingency plan relating to that life preserving service; and

(c) the support it requires from union members.

(4) A request must be made by the close of the day after the date of the notice of industrial action.

(5) As soon as practicable after the employer has made a request but not later than 4 days after the date of the notice of industrial action, the parties must meet and negotiate in good faith and make every reasonable effort to agree on –

(a) the extent of the life preserving service necessary to provide for patient safety during the industrial action; and

(b) the number of staff necessary to enable the employer to provide that life preserving service; and

(c) a protocol for the management of emergencies with require additional life preserving services.

(6) An agreement reached between the parties must be recorded in writing.

*13. **Adjudication***

(1) If the parties cannot reach agreement under clause 12(5) they must, within 5 days after the date of the notice of industrial action, refer the matter for adjudication by a clinical expert or other suitable person as agreed under clause 8.

(2) The adjudicator must conduct the adjudication in a manner he or she considers appropriate and must –

(a) receive and consider representations from the parties; and

(b) in consultation with the parties, seek expert advice if the adjudicator considers that it is necessary to do so; and

(c) attempt to resolve any differences between the parties to enable them to reach agreement and, if that is not possible, make a determination binding on the parties; and

(d) provide a determination to the parties as soon as possible but not later than 7 days after the date of notice of industrial action.

(3) The parties must use their best endeavours to give effect to the determination.

(4) The parties must bear their own costs in relation to an adjudication."

[10] Here it is important to note that the primary obligation to provide for patient safety lies with the employer. It is the employer who is to ensure that life preserving services are available to prevent a serious threat to life or permanent disability. Where an employer's contingency plans are insufficient to provide life preserving services without the assistance of members of the union, the employer must make a specific request of the union to provide such services.

[11] It is implicit in the Code that the union must provide such services where the request is a reasonable one, taking into account the parties' commitment to the safety of patients.

[12] Life preserving services are defined in the Code as meaning:

"(a) crisis intervention for the preservation of life:

(b) care required for therapeutic services without which life would be jeopardised:

(c) urgent diagnostic procedures required to obtain information on potentially life-threatening conditions"

[13] The Code also provides for remedying breaches of good faith as set out below:

*"22 **Notice of breach***

If a party believes that another party has breached the duty of good faith in section 4, it must bring this to the attention of the party in breach at an early stage.

23. ***Obligation of party in breach***

A party in breach must –

(a) if the breach can be made good, make good the breach by making every endeavour to restore the other party to the position the other party was in before the breach; or

(b) if the breach cannot be made good, provide an explanation to the other party."

[14] On 10 October, the parties settled a life preserving services agreement in relation to the radiation therapists' strike following adjudication by Mr Andrew Connolly, a surgeon who is head of the Department of General Surgery at Counties Manukau DHB.

[15] The life preserving services agreement provides as follows:

"Without prejudice to the duty of the DHB to request the Union's assistance as a last resort only, it is agreed that if there is an event that exhausts the DHB's contingency plan utilising all available alternative resources including non members, then APEX shall provide an appropriate response to deliver LPSs as provided below:

1. *Life Preserving Services (LPSs) have been agreed as radiation treatment for acute deterioration in malignancies resulting in the following conditions:*
    a. *Super vena cava obstruction.*
    b. *Life threatening haemorrhage not amenable to surgical treatment.*
    c. *Acute Airway Obstruction.*
    d. *Cord Compression (although below C3 is not life threatening, APEX is happy to include any cord compression).*
2. *CCDHB will reduce services in the period leading up to the strike and take all other steps possible so as to minimize the need for LPSs by union members during the period of the strike.*
3. *The DHB will do everything within its power to manage 'creep' including impressing on staff and managers the importance of not abusing the system and monitoring the situation on a daily basis.*
4. *All calls for our members support will be made from the clinical leader. We will require confirmation of what our members have been requested to do by 0900 the following day or within 24 hours whichever is the earliest to monitor compliance. This can occur manually with the RT recording cases or through another automatic system if you have one. The abuse of the agreed LPS parameters may result in withdrawal of cover.*
5. *Our members will be paid as per their normal entitlements during the periods in question.*
6. *Further to clause 12(5)(c) of the Code of Good Faith for the Public Health Sector, should any unforeseen event occur that requires more assistance than that arranged by CCDHB with non members during the period of the strike, for instance in the event of those working falling sick, joining APEX or multiple presentations of LPS patients unable to be safely handled by the non member staff CCDHB have arranged, APEX will be contacted to provide additional cover for LPSs (as defined above) by agreement.*
7. *Any breach of this agreement, such as the use of an APEX member without all alternatives having been exhausted, shall constitute a breach of good faith."*

[16] During the course of the strike, the treatment of a patient known as Patient A came into question. This patient was under the treatment of Dr Carol Johnston, a radiation oncologist employed by Capital & Coast. Ultimately it was Dr Johnston who was responsible for any radiation therapy provided by radiation therapists to Patient A.

[17] Dr Johnston had been treating Patient A for about six months at the time of the strike. Patient A was an 85 year old woman who was suffering from the early stages of two types of cancer, both of which were likely to prove terminal. She was prone to lose blood as a result of the effects of the cancers. Because she had been declined surgery because of her age and health status (including a heart condition), radiotherapy was the only treatment likely to be effective in controlling any bleeding she suffered from. Patient A had been admitted to hospital twice before under Dr Johnston's care where blood transfusions were required. She had been given radiotherapy on two previous occasions to good effect.

[18] Patient A was readmitted to hospital on 14 October because of evidence of bleeding. She was given a blood transfusion but the Registrar assessed her as being haemodynamically stable, in that her pulse was not elevated and her blood pressure was not down. The Registrar categorised Patient A's need for treatment as category C, which meant that in the ordinary course of events her treatment would begin within four to six weeks.

[19] Dr Johnston met with Patient A on 18 October. She discovered that there was no evidence that Patient A had stopped bleeding. Given her knowledge of Patient A's history, Dr Johnston was very concerned because, in the past, her bleeding had only been of a short duration. She was also concerned because of Patient A's age and her heart problems that she could have a major haemorrhage as a result of the cancer(s) expanding and that this would be life threatening in that it would have been very likely that she would have died should that sort of haemorrhage occur.

[20] Dr Johnston therefore re-categorised Patient A as requiring urgent treatment (category A). Dr Johnston was unprepared to take the risk of even a 24 hour delay as that would mean that Patient A's bleeding could progress to a life threatening haemorrhage. It would be too late to provide radiation treatment to control the bleeding once a major haemorrhage had occurred. Dr Johnston arranged for an IV line to be put into Patient A so that she could be treated quickly in the event of an emergency, but that line later tissued and had to be replaced, although for some reason this did not appear to have been done immediately.

[21] While Dr Johnston was confident that Patient A could be provided with treatment in the normal course of the working day (i.e. before the strike period commenced), she felt that it would

be prudent to approach the Union under the Life Preserving Services Agreement in case treatment was delayed for any reason. During her discussions with DHB management, Dr Johnston disclosed her knowledge that Patient A was the mother of a senior Capital & Coast employee, but that that had played no part in her decision to re-categorise Patient A.

[22] DHB staff put the request to the Union's delegate on site. Basically that delegate was told that Patient A had an acute bleed and therefore the Union agreed to treatment, believing the life preserving services criteria had been met. As it happened, Patient A's treatment was completed within the scheduled time and therefore services did not need to be provided by union members under the Life Preserving Services Agreement.

[23] The delegate later questioned whether the patient did qualify under the criteria because she was discharged three days later and because she informed radiation therapists in general conversation that her son was employed in a senior position at the DHB.

[24] The delegate took the matter up with Dr Powell, who wrote to Meng Cheong, the Chief Operating Officer of Capital & Coast, on 25 October in the following terms:

> *"On 18 October 2006, APEX was requested to provide an LPS service to a patient as a category A patient …*
>
> *We have subsequently learnt that the patient could reasonably have been treated the following day, although some shuffling of other patients would have been needed. Furthermore we are concerned that the patient was in fact not an LPS at all as defined by the above agreement. Specifically the patient had a relatively long history of slow bleeding and was not at the time the request was made, suffering from an 'acute deterioration' nor was it a 'life threatening haemorrhage'.*
>
> *If our information is correct, this would constitute a breach of our agreement and automatically a breach of good faith. We therefore request you investigate this issue and respond to us urgently with sufficient clinical details to prove the request was in fact compliant with the above LPS definition.*
>
> *If upon investigation you consider our assessment of the situation is in fact correct (i.e. this was not an LPS), please confirm and state what steps CCDHB will take to ensure a repeat breach of the LPS agreement does not reoccur."*

[25] The DHB replied the next day noting that there had been no breach of the Code on the basis that treatment had been completed within normal working hours, that the radiation oncologist believed patient A was suffering from a life threatening haemorrhage not amenable to surgical treatment and that this was properly notified to the Union in advance.

[26] Dr Powell wrote back on 27 October noting that the Union expected the DHB to confirm with them blood pressure and pulse recordings proving the DHB's point. Dr Powell therefore requested an independent clinical review of the patient's notes to confirm whether the patient was in fact an LPS and suggested Mr Connolly to do that work. In particular, the Union raised its concerns

that Patient A's blood pressure and pulse were not consistent with what would normally be expected in a life threatening haemorrhage, that her condition would be better described as a chronic bleeding condition, that she had previously been determined as category C, that she was haemodynamically stable and that other patients could have been re-scheduled.

[27] Dr Powell noted that:

> *"If our concerns are found to have substance, the trust with which we can approach future LPS requests from CCDHB will have to be re-evaluated."*

[28] Dr Powell also had a conversation about the matter that day with Ms Chris Lowry, the DHB's Business Manager – Medical and Surgical. In that phone call Dr Powell opined that the Union should never have been asked to implement the life preserving service agreement in this case. She wanted the matter put through adjudication because she questioned the DHB's veracity and in fact at one point called the Board a *"pack of liars"*. I accept that Dr Powell used this language in that phone conversation, based on my acceptance of Ms Lowry's note made at the time and the fact that Dr Powell, while denying using those particular words, did accept that the Union at that time was having other issues with the DHB which led her to doubt its veracity on other matters. Dr Powell also indicated that the oncologists were coming from a clinical perspective, not a legal one, and therefore did not know what they were talking about. She also alleged that treatment was provided on the basis of Patient A's family connections.

[29] Capital & Coast replied to the letter of 27 October the next day, stating that it would confirm the clinical details in writing to Dr Powell, but in light of the seriousness of the issue, both for the current alleged breach and the future relationship between the parties, it would be seeking an independent evaluation of its decision-making. Dr Powell replied that she assumed Dr Connolly would be the independent assessor and that if the Union was given the clinical details forthwith, it may be possible to avoid the need for an independent assessment.

[30] By 31 October, Ms Lowry was acting as the Chief Operating Officer of Capital & Coast. She replied to Dr Powell on 31 October in that capacity, notifying the Union that an independent radio oncologist would be doing the review and that the DHB did not accept that Mr Connolly was the appropriate person to do such review. The Board's approach was said to be to *"establish whether such a breach occurred and act on any deficits should they proven"*.

[31] No doubt because of the tensions between the parties, the DHB agreed to investigate the matter as a priority. It therefore undertook to complete its internal investigation by 3 November.

[32] The Union wrote back to Ms Lowry on 1 November indicating it did not accept that the assessment could be independent when the Board chose the assessor. The Union suggested that Mr Connolly was appropriate because he had previously been an agreed independent arbitrator, but also suggested another specialist as an alternative. The Union also noted that the clinical information had not been provided and requested an immediate response. Dr Powell also suggested some ways of ensuring any patient confidentiality was met.

[33] On 1 November, Capital & Coast approached a radiation oncologist with another DHB, Dr Shaun Costello, to provide his assessment of whether Patient A's treatment should have been covered by the life preserving agreement.

[34] On the basis of the short summary provided by Dr Johnston, which was not backed up by the medical records, as they were unavailable, Dr Costello's initial assessment made that day was that:

> *"The patient was haemodynamically stable and hence her life was not at risk AT THE TIME radiation was requested. The key phrase is life threatening.*
>
> *Hence this treatment failed the LPS criteria and as such would be classified as palliative and thus excluded.*
>
> *This I know seems bizarre and uncaring and could potentially put the patient at risk however the LPS criteria do not require an assessment of risk as defined.*
>
> *I have tried to contact Carol but have had no success. I am happy to discuss further the clinical info may be incomplete."*

[35] On 2 November, Ms Lowry replied to the Union stating that it would share the outcome of its review and the independent assessment once it had been completed. Dr Powell replied the same day stating that the Union would not be bound by any internal review and that it was entitled to the clinical details which "*must be provided to us* ***immediately***". The DHB was told that if it did not, this failure in itself would constitute a breach of good faith.

[36] In the meantime, Dr Costello had spoken to Dr Johnston, who told him she believed the patient was at risk of a re-bleed and that although stable at the point the request was made, she could become unstable at any time. Dr Costello discussed the issue with a number of surgeons at his DHB and they confirmed that such patients are at risk of developing an unpredictable catastrophic uncontrollable bleed.

[37] Therefore, Dr Costello changed his opinion to conclude that an adjudicator:

> *"…WOULD interpret 'LIFE THREATENING' to include this scenario.*
>
> *I should be grateful if this finding could be communicated to Carol who is obviously rightly distressed by this episode."*

[38] On 3 November, Ms Lowry provided the Union with what it considered to be its final response. Ms Lowry included what appeared by its layout to be a report by Dr Costello, but was in fact an amalgam (with some deletions) of a series of emails provided by Dr Costello.

[39] By way of summary in the letter of 3 November, Ms Lowry wrote:

> *"The decision is inconclusive and opinion varied. Acknowledging that we are evaluating all of this with the benefit of hindsight, and a range of medical opinion, we cannot establish any proof of breach of good faith. Indeed, by pursuing the independent evaluation we are putting increasing pressure on staff in a department which has been unable to function normally since late September (five weeks).*
>
> *CCDHB stands behind the decision of its radiation oncologist to seek radiation treatment of this patient on this day and, while there is some reservation from Dr Costello as to whether it technically meets the LPS definition, this is not the view of our staff or the GI surgeons at Otago District Health Board. We intend to follow up with our medical staff next week as above, to ensure we provide ongoing support to the decision-making and departmental management. We intend to take no further action, nor to provide APEX with further information."*

[40] The next week the Union wrote to the DHB stating it had no confidence in its ability to handle this or future matters honestly. Therefore, the Union indicated that all future requests for life preserving services would be actively scrutinised by it prior to being authorised, and this would be done by Dr Powell herself. The Union also required prior provision of clinical details confirming any request for consideration and noted that any abuse of the agreed parameters may result in withdrawal of cover. It was also indicated that APEX would be pursuing the matter now before the Authority.

[41] In its reply to Dr Powell's later letter, the DHB indicated again that it would be taking no further action or providing any further information to the Union and that until proven to be wrong by the Authority, it would be continuing with its existing processes.

[42] On 16 November, the Union's lawyer, Mr Manning, sought all the background information provided to Dr Costello, together with his report and the patient records. Dr Coates wrote back on behalf of the Board, indicating that all the clinical information provided to Dr Costello had been provided to the Union and that the Union was not entitled to Patient A's confidential health records. Capital & Coast did agree, however, to reconsider the matter if the Union could provide it with legal authority that established the Union's entitlement to access to and a requirement on the DHB

to provide the information. Full details of the emails between 1 and 3 November were provided to the Union with that letter.

[43] Two weeks later, the statement of problem referred to above was filed with the Authority.

[44] In the investigation meeting, no claims were made that Patient A's family relationships made any difference in her treatment. I accept that although this was a reason that the Union wanted to scrutinise the request for life preserving services for Patient A, there was in fact no cause to suspect Dr Johnston's motives in this regard. Quite rightly the matter has been taken no further.

[45] Evidence was given by Dr Powell, however, that Patient A's condition did not warrant recourse to the life preserving agreement. Dr Powell referred to the relative stability of Patient A, that the bleeding appeared to have stopped, that she should have had an IV bore in her if her position was precarious and to her release from hospital three days later. Dr Powell noted the tension in the Code of Good Health between the need for patient safety and the need to allow unions to operate within the freedoms provided in the law, including the right to strike. She also gave evidence that people die all the time in hospitals and that this needs to be taken into account.

[46] Dr Powell was not present during the evidence given by the medical specialists in this case, namely Dr Costello, Dr Connolly and Dr Roger Allison, the Dean of the Faculty of Radiation Oncology of the Royal Australian and New Zealand College of Radiologists. While surgeons focus on slightly different issues than oncologists, because of the nature of their specialities, the consensus was reached during the investigation meeting by them (especially once it had been established that an IV bore had been fitted to Patient A) that Patient A was at high risk of a life threatening haemorrhage not amenable to surgical treatment. I note that, in terms of the Life Preserving Services Agreement, this condition could be compared with cord compression. In the case of cord compression, it is the threat of cancerous growths impacting on the spinal cord that is in issue, rather than its existence, because once the spinal cord is affected, radiation treatment is of no effect. Thus, consensus from the specialists was that a patient in Patient A's situation would normally be given treatment within 24 hours because of the risks to her life and therefore it was appropriate to have sought the Union's assistance under the Life Preserving Services Agreement.

[47] While Dr Powell was not present for this evidence, I presume it was conveyed to her because overnight the Union withdrew its claim in relation to Dr Johnston's request. It was clear therefore that Dr Johnston made not only the right medical decision, but also the right decision in terms of the agreement between the parties.

Determination

[48] On behalf of the Union, Mr Manning made the point that requests under the Life Preserving Services Agreement can fall under one of three heads, namely obviously necessary, unclear as to necessity and clearly not necessary. The Union accepted that an employer would only be in breach of the Life Preserving Services Agreement in the latter category and that this case was not one.

[49] I agree with the Union's assessment made in submissions as entirely appropriate. With lives potentially at stake it is necessary to take a very broad view of what constitutes life preserving services under the Code of Good Faith for Public Health Sector. While deaths may occur all the time in hospitals as Dr Powell pointed out, the purpose of the Code and Life Preserving Services Agreements is to ensure patient safety and limit deaths by requiring the parties to industrial action to provide life preserving services. Thus it is the potential risk (or jeopardy) to life rather than the actual existence of risk to life that must be considered in interpreting the Code. No doubt this is why the Code includes therapeutic and diagnostic procedures within the definition of life preserving services. The agreement must also be interpreted in this light, as it must be consistent with the Code. The opinions of the medical professionals responsible for a patient's care must be given great credence in any assessment, although employers must ensure that they minimise the use of workers who would otherwise be on strike, including putting in place systems to ensure that medical professionals do not let their duties to their patients override agreements entered into between unions and employers under the Code (known colloquially as the need to avoid "creep"). It was clear from the evidence before the Authority that this did not occur in this case.

[50] Clause 32 of the parties' collective employment agreement provided for personal grievances, disputes and employment relationship problems. A dispute is an employment relationship problem under the agreement. Where a dispute arises, the parties are required in the first instance to seek to resolve it between the immediately affected parties. If the matter is not resolved either party is entitled to seek mediation from the Labour Department or refer the matter to the Employment Relations Authority.

[51] The Life Preserving Services Agreement did not provide for any mechanism for dispute resolution. Any dispute therefore is an employment relationship problem, which is to be dealt with by direct discussion, mediation and adjudication before the Authority. There is no requirement for Capital & Coast to do more than that, except that it must meet the requirements of the Code, including communicating openly and effectively, and provide information in a timely manner. There is no requirement on the DHB to involve the Union in what in effect was its own internal review, except to the extent that it had undertaken to do so. I am satisfied on the evidence that,

despite the tensions between the parties at the time, the DHB kept APEX, through Dr Powell, informed of its actions in a timely manner and gave her as much information as was necessary, albeit that APEX made it clear that it wanted matters dealt with differently. For example, Capital & Coast did not sit on its hands but rather implemented an independent review within a very short timeframe. Furthermore, I accept that the relevant clinical details were provided to the Union by the DHB in its letter of 3 November and that Drs Costello and Allison considered that this information would have been sufficient for them to make an assessment.

[52] I accept, however, that things would have gone more smoothly had the Union been more involved in the process. This is a matter the parties might reflect on, even although under the terms of the employment agreement and the Code, Capital & Coast's failure to do so is not a breach of good faith.

[53] Even although I accept that the Union did not believe that Dr Costello would act in an even handed manner in conducting his review, the Union had no right to object to the DHB selecting him to conduct the review. Furthermore, it was clear from Dr Costello's initial view that Dr Johnston's request did not meet the agreement's criteria that he did in fact act in an independent and unbiased way.

[54] I do not accept that the DHB deliberately sought to obscure what had happened from the Union. Clearly relationships between the parties were tense, as evidenced by the inconvenience caused by the strike (which was clearly resented by some of the Board's staff) and Dr Powell's description of the Board and its employees as a pack of liars. Perhaps as a result, the Board did not give the Union all the information it requested at the time it requested it, but in doing so, did not breach any legal duty to the Union, for the reasons given above.

[55] It was also clear from the evidence of the specialists that the material provided to Dr Costello by Dr Johnston was sufficient for an assessment to be made of the need for urgent treatment of Patient A. It follows that the Union, which was given this information on 3 November, was given sufficient information to assess for itself whether the agreement's criteria had been met.

[56] The Union was, however, quite right to claim that it had been misled about the review as a result of the Board's letter of 3 November. The way Ms Lowry compressed a series of emails into what would appear to a reader as one report meant that the degree of re-assessment undertaken by Dr Costello and his colleagues was not clear. However, I am satisfied from Ms Lowry's evidence that she did not remove material, much of which was in effect social niceties (although this did show Dr Costello's personal sympathy for Dr Johnston), for the purpose of misleading the Union.

The key points that Dr Costello had changed his mind and had done so following discussion with other surgeons were included in the quotations provided. Furthermore, any prejudice to the Union was remedied by the provision of the emails in full some two weeks later. Considered in the round, I find that this relatively minor failing does not constitute a breach of good faith.

[57] I am also satisfied that Capital & Coast was not required to provide Patient A's medical notes to the Union until the time that it did so, because of the confidentiality quite rightly accorded to the patient's health information and the fact that given the patient's age and state of health, it would have been inappropriate for it to approach her to seek an agreement to the release of the information.

[58] I therefore conclude that Capital & Coast did not breach its duty of good faith to the Union and therefore dismiss the Union's claims.

[59] Finally, it is also important to note that I agree with the Union's view that the Authority is probably not best placed to determine disputes about the use of life preserving services. Instead, such matters would probably be better determined by an independent medical specialist acting in an advisory and/or decision-making role. This is because a decision made to invoke the Life Preserving Services Agreement is in effect a medical decision (albeit with a legal overlay) and is thus better decided by medical specialists, who can give practical effect to the intent of the parties under their agreement. I would therefore recommend that the parties agree in any future life preserving service agreements on a method for the informal, speedy and final determination of any disputes that may arise under the agreement.

Costs

[60] Costs are reserved.

G J Wood
Member of the Employment Relations Authority