Otago District Health Board

A Report by the

Health and Disability Commissioner

(Case 07HDC05942)

Parties involved

Mr A	Consumer
Ms B	Complainant/Consumer's partner
Otago District Health Board	Provider
Dr C	Neurologist
Dr D	Neurosurgeon
Dr E	Specialist, Intensive Care Unit
Dr F	Locum in general practice
Dr G	Registrar

Complaint

On 1 March 2007 the Health and Disability Commissioner (HDC) received a complaint from Mr A and Ms B about the services provided to Mr A by Otago District Health Board. The following issue was identified for investigation:

Whether Otago District Health Board provided Mr A with services of an appropriate standard on 18 and 19 November 2006.

An investigation was commenced on 28 May 2007.

Information reviewed

Information was received from:

- Mr A
- Ms B
- Dr E, Specialist, Intensive Care Unit
- A medical centre
- Otago District Health Board

Independent expert advice was obtained from Dr Geoffrey Robinson, physician and Chief Medical Officer of Capital and Coast District Health Board, and neurologist Dr Richard Frith. Their advice is attached as Appendix 2.

Overview

At 11am on Saturday 18 November 2006, Mr A was referred to the Emergency Department (ED) at Dunedin Hospital after a consultation at an after-hours medical centre. His speech was sluggish and he was unable to maintain his balance. Mr A was accompanied by his partner, Ms B. At 4pm he was seen by neurologist Dr C, who advised Mr A that he needed an MRI head scan. However, because the medical radiation technologists (MRTs) at Dunedin Hospital were on strike, Dr C suggested that Mr A go to the local private hospital for the MRI. The day before the strike started, information had been sent to clinical staff about life-preserving services and the process for recourse to MRTs. Dr C did not consider that the clinical situation fell within the criteria for life-preserving services.

The MRI equipment at the private hospital was out of action, and Mr A was admitted to the Dunedin Hospital neurology ward for observation. On the morning of 19 November Mr A's condition began to deteriorate. At 3.40pm Dr C was advised that there had been a significant deterioration in Mr A's condition. Dr C assessed Mr A and advised him of the need for an urgent MRI. He then spoke to the Chief Medical Officer (CMO) in accordance with the process for requesting radiology services during the strike. An urgent MRI was performed and the report was issued at 6pm. It showed features consistent with an acute cerebellar bleed. At 7pm Mr A underwent urgent surgery to drain a cerebellar abscess, and was transferred to the intensive care unit for his postoperative recovery.

Information gathered during investigation

Initial presentation
On Saturday 18 November 2006 Ms B took her partner, Mr A (50 years old), to a medical centre because his speech was sluggish and he was unable to maintain his balance. He had had two falls at home. Mr A had a history of diet-controlled diabetes mellitus, hypertension, and hyperlipidaemia.

Mr A was seen at the medical centre by Dr F, a locum in general practice. Dr F recorded Mr A's clinical history as:

> "Unwell since Monday, attributed to sunstroke mountain biking at weekend. Was working [in another city], spent a day in bed then forced himself to get up and drove back to Dunedin on Thursday. Seen [at a medical centre] diagnosed labyrinthitis."

Dr F noted that Mr A's symptoms had become more severe in the 24 hours prior to his arrival at the clinic. He was not vomiting, but had fallen twice. She noted that he had diet-controlled diabetes and was not on any medication.

Dr F recorded that Mr A, on clinical examination, was fully conscious, alert and responsive. His blood pressure was elevated at 174/101mm/Hg and his temperature was not raised. His random blood glucose was high at 12.4mmol/L. She noted that he was unable to walk unaided as a result of poor balance. His speech was slow, deliberate, slightly squeaky and slurred, but the content was normal and appropriate. On neurological examination, Mr A had bilateral lateral gaze nystagmus,[1] and finger–nose coordination was impaired on the left.

Dr F considered that Mr A might have suffered a cerebellar stroke.[2] She referred him to the on-call medical registrar via Dunedin Hospital ED.

Assessment at Dunedin Hospital

At around 11am on 18 November Mr A was taken by ambulance to the ED at Dunedin Hospital, accompanied by his partner, Ms B. At 12.20pm nursing staff recorded his pulse rate of 67/min, blood pressure 168/110mmHg, and Glasgow Coma Score (GCS)[3] of 15/15. At 12.44pm the ED doctor saw Mr A. She noted the onset of ataxia (an inability to coordinate voluntary muscular movements), nausea and vomiting four days previously. Two days earlier he had been prescribed an anti-emetic, Stemetil, which had settled the nausea and vomiting. On clinical examination, she found that Mr A's speech was not clearly articulated. The coordination of his upper and lower limbs was impaired, left more than the right, and he had gross ataxia on standing. Her impression was that Mr A had had a cerebellar stroke. She planned for blood tests, an electrocardiogram, and review by the medical registrar. She noted that a CT scan could not be done routinely owing to the MRT strike.

Ms B stated, "He spent the next five hours undergoing the same neurological tests he had undergone at the [medical centre]." Mr A was extremely tired and his ability to perform the neurological tests was diminishing. Ms B said, "It appeared to me that hospital staff thought that a scan was needed — but hands seemed to be tied. No-one could authorise one because of the radiographers' strike."

At 1.20pm, Mr A was seen by a fourth-year medical student who conducted a comprehensive assessment. At 3.20pm Mr A was reviewed by a medical registrar. The medical registrar recorded that he discussed Mr A's condition with the neurology team and whether there was a need for him to have an MRI or CT scan.

[1] Nystagmus is the involuntary, usually rapid movement of the eyeballs (eg, from side to side), which can occur abnormally following head injury or as a symptom of disease.

[2] The cerebellum is a large dorsally projecting part of the brain concerned especially with the coordination of muscles and the maintenance of bodily equilibrium.

[3] A numerical system used to estimate a patient's level of consciousness after head injury. Each of the following are numerically graded: eye opening response (4), motor response (6), and verbal response (5). The higher the score, the greater level of consciousness. Patients with scores of 3–8 are usually said to be in a coma.

At 4.25pm, neurologist Dr C examined Mr A with the medical registrar. Mr A complained of a headache, which had started a week earlier, nausea and vomiting, which relieved the headache, and balance and incoordination problems. Dr C noted that Mr A was alert, his heart rate was 68 beats per minute, and his blood pressure was elevated at 168/110mmHg. He also noted slightly dysarthric speech[4] and bilateral nystagmus, but no significant pathology other than features suggestive of cerebellar dysfunction. He considered the absent ankle reflexes to be related to diabetes mellitus. As Mr A did not have a raised temperature, Dr C considered that he did not have any underlying infective process at the time.

Dr C advised Mr A that his condition was serious. However, he considered that Mr A's condition did not meet the criteria for requesting life-preserving services (LPSs), according to the written information he received before the MRT strike (discussed below). Dr C did not contact the Chief Medical Officer (CMO) or discuss the matter with the radiologists. He recorded:

> "After examining [Mr A] in the presence of [the] (Med registrar on call) and [Mr A's] partner he was informed that he requires an MRI scan to establish the exact nature of the pathology to the (R) cerebellar hemisphere as clinically indicated — It is suggested that he either has a intracerebellar haemorrhage and/or cerebellar infarction — primary or secondary to dissection of vertebral/basilar or post occip. [posterior occipital] artery.
>
> Currently his life is not in jeopardy but it is recognised that with expansion of a haemorrhage occlusion of the 4th ventricle can occur which would result in an acute situation which is life threatening. A CT or MRI is indicated in this condition but due to the strike of the MRTs [medical radiation technologists] this procedure cannot be performed. [Mr and Mrs A] have been informed of the situation which prevails and an attempt is being made to obtain a scan privately to which they have agreed — Failing this (weekend) his condition will be monitored very closely and if any change in his condition indicates change, risk and development of life threatening situation the necessary steps will be taken to immediately obtain the necessary permission for scanning."

Ms B stated that Dr C suggested that as Mr A had health insurance they should try to arrange for a scan to be done at the private hospital. However, at 5pm Mr A and Ms B were informed that it was not possible to have the scan done at the private hospital because their scanner was "out of action".

Care on the ward

At 5.35pm Mr A was taken to the neurology ward 5B at Dunedin Hospital under the care of Dr C. The nursing staff recorded that Mr A's neurology observations were to be recorded hourly "for the next few hours to watch for any change".

[4] Difficulty in articulating words owing to disease of the central nervous system.

At 8.45pm Mr A was seen by the on-call house surgeon because of nausea. He continued to suffer from a headache, but was found to be clinically stable. At 10.18pm the medical registrar on call also noted the continuing headache. The night staff monitored Mr A throughout the night with two-hourly neurological observations, and noted that he slept well in between cares. His GCS remained at 15/15.

When Ms B arrived in the ward at 9am on Sunday 19 November, she noticed a "considerable deterioration" in Mr A's condition. His speech was more sluggish and in between dozing off he appeared to have reduced mental function because he kept repeating himself when talking to her.

At 10.30am registrar Dr G was informed that the nurses were concerned about Mr A's GCS level. Dr G examined Mr A and recorded his GCS to be stable with no significant hypertension or slow heart rate. Dr G recorded the treatment plan for Mr A:

> "Continue observations Q2H [two hourly]
> neuro observations Q4H [four hourly]
> Consider less observations from midnight to 6am tonight if all above observations remain stable. If significant deterioration for assessment to consider life saving head scan."

Ms B felt that she was watching Mr A deteriorate before her eyes and kept questioning what was being done about organising an MRI scan. She was concerned about the delay in obtaining a scan for Mr A. Ms B felt that Dr G was unwilling to listen to the family, and reluctant to seek further advice about an LPS. Ms B was disappointed that no one contacted the Chief Medical Officer (CMO), as the gate-keeper to LPSs, to inform him of the situation. Ms B left the hospital at 11am hoping that Mr A would get some sleep.

At 11.15am the on-call house surgeon was called to see Mr A, because he had fallen out of bed and injured his head. The clinical notes state that the nursing staff heard a "bang" and found Mr A on the floor. There were no witnesses to the fall. He had sustained a contusion to the right side of his forehead and a small laceration, and a contusion to the bridge of his nose. Staff did not contact Ms B about the fall.[5]

Mr A's neurological observations remained stable until about 2.40pm when he became restless and incontinent of urine. At 3pm Ms B returned and noted that Mr A was restless and his head appeared to be sore. At 3.25pm Dr G was called to see Mr A and recorded a GCS of 12/15 with fluctuating confusion. Dr G notified Dr C about the change in Mr A's condition.

[5] Ms B subsequently expressed frustration about the lack of contact by hospital staff following the fall, particularly as she had just left the hospital.

At 3.40pm Dr C reviewed Mr A. He noted that Mr A had "significantly deteriorated during preceding hours" and suspected either an enlarging left cerebellar hemisphere bleed, development of hydrocephalus and coning, or an additional injury, such as a subdural haematoma. Dr C noted:

> "Further management of the patient is critically dependent on obtaining a life sustaining scan. Delay in my opinion could result in death and/or significant morbidity if not provided."

At 3.45pm Dr C spoke to the CMO and gained authorisation for Mr A to have an MRI. At 4pm Dr C updated Ms B.

Dr C indicated the clinical details on the MRI request form: three days of left-sided ataxia; presented with intracerebellar haemorrhage with left-sided signs; GCS worsening; increased agitation; and falls with deteriorating level of consciousness. The imaging was performed at approximately 5pm and the report was issued at 6pm. It showed an irregular rounded area measuring approximately 5.3 x 3.8cm within the left cerebellar hemisphere consistent with a hyperacute haemorrhage, considered to have occurred within the preceding six hours. There were also a few smaller areas of haemorrhage and evidence of mass effect. The impression was of a left cerebellar haemorrhagic infarct with mass effect. This was compatible with the clinical impression of a cerebellar stroke and deterioration in Mr A's condition in the preceding hours, which indicated further expansion of the haemorrhage.

Neurosurgical care

Dr C urgently contacted the on-call neurosurgeon, Dr D, who recorded that the acute bleed on the MRI looked "unusual" and considered the possibility of a tumour or abscess. Dr D felt that Mr A needed urgent surgery, and he was taken to the operating theatre.

Dr D performed a craniectomy and drained and excised a large left cerebellar abscess. The abscess ruptured spontaneously and copious foul-smelling pus was drained. An urgent Gram stain showed mixed organisms, and Mr A was commenced on intravenous antibiotics: ciprofloxacin, flucloxacillin, and metronidazole.

After surgery, Mr A was transferred to the intensive care unit for close observation. He remained on a ventilator until 21 November. CT imaging on 20 November showed that the abscess had been successfully drained and there was no surgical complication. On 22 November, Mr A was transferred to the neurosurgical high dependency unit. Given the highly unusual type of abscess, investigations were undertaken for potential sources of infection, but no source was identified.

Mr A slowly recovered and was discharged home on 13 December. At the time of his discharge most of his presurgical neurology had resolved, but there were persisting signs of dys-coordination and moderate ataxia (unsteady gait). Arrangements were

made for the District Nurses to administer daily intravenous antibiotics and for the Diabetic Service to monitor his diabetes.

Intravenous antibiotics were stopped on 9 January 2007 when inflammatory markers returned to normal levels. Mr A remained on oral antibiotics until 15 February 2007. At a neurosurgical outpatient appointment on 1 May 2007, Dr D noted no significant residual left cerebellar neurological signs or surgical complications.

Otago District Health Board's arrangements for MRT strike
Otago District Health Board (DHB) developed a number of documents relating to the management of patients during the Medical Radiation Technologists' (MRTs) strike in November 2006. The "Contingency Plan for Otago DHB: Medical Radiation Technologists November 2006" sets out the DHB's key objectives, general principles and strategies, and the details of the plans put in place during the strike. This included plans for each service. The service plan for the ED included, "Agree criteria for assessing Radiology requests", and the service plan for Medical included, "Agree criteria for LPS and access to Radiology". Otago DHB's criteria for assessing radiology requests were the Code of Good Faith for Public Health Sector and the agreement between Otago DHB and the union APEX. The coordination countdown plan stated: "Daily update to all staff" from 27 October to 31 October 2006.

On 9 November 2006 Otago DHB (via an email from the CMO) distributed "a strike contingency information pack" to clinical staff. This set out the processes in place for determining who received radiography services, and included four attached documents:

1. *The CMO's notice "To All Medical Staff" outlining issues relating to the management of patients during the time of the strike.*

In the notice, the CMO stated that there would be a 10-day strike by MRTs starting on Friday 10 November at 4.30pm. He referred to an attached copy of the agreement between the union and the DHB about the meaning of LPSs, which would be available during the strike period. He noted that on that day (ie, Thursday 9 November 2006), the union and DHBs were in mediation and it was hoped that the notice would be of "academic interest" only.

The CMO stated in the notice that during the last MRT strike, the DHB was considered to be in breach of the agreement, and put on notice by the union. He indicated that the consequence of being found in breach would be total withdrawal of services including LPSs. He stated: "We have a responsibility to try and manage the situation to the best of our ability. To breach our agreement would be putting our patients at even further risk."

The notice set out the procedure for an LPS. The consultant caring for the patient must contact the CMO (or delegate), who decides whether the case fits the criteria. The request form must include full clinical details and a number provided by the CMO, and be faxed to the duties office to contact the MRT and radiologist. The CMO

stressed the importance of fully informing patients of the ideal way to manage or investigate their problem, and what could be done during the strike.

He added a statement (taken from advice from the DHB's external lawyers) that clinical decision-making "will involve weighing up the available contingency plans and also whether the situation meets the parameters of the agreement on LPS".

2. *Agreement for the provision of Life-preserving Services Between Otago DHB and APEX For the periods of industrial action from 0701 November 14, to 0730 November 20, 2006 dated 5 November 2006* (the Agreement).

In the Agreement, the Otago DHB and the union APEX (Association of Professional and Executive Employees) agreed "that if there is an event that exhausts the DHB's contingency plan utilising all available alternative resources, then APEX shall provide an appropriate response to deliver LPS". It was agreed that the DHB would call on the services of APEX MRT members for LPSs only as a last resort. It sets out examples of situations considered as LPSs, which included:

> "Triage 1 and triage 2 ED patients that involve LPS will be accepted given that all attempts to decant and/or redirect will have been made. This includes patients with imminent respiratory, circulatory or neurological collapse or substantial risk of such collapse where radiological services are mandated for diagnosis or treatment (i.e. clinical diagnosis or alternative mechanisms for diagnosis or treatment are not available)."

The Agreement sets out the process for recourse to APEX members, and states that the CMO "shall call the MRT providing LPS for the particular circumstance where assistance meets the requirement of this agreement". It concludes, "Any breach of this agreement, such as the use of an APEX member for non LPS events or without all alternatives having been exhausted, shall constitute a breach of good faith."

3. *A flow chart, "Final LPS Process 9th November 2006" which sets out the steps a consultant must take for requesting an LPS, and explained in the CMO's notice* (attached at Appendix 1).

4. *A flow chart, "Final Process for non LPS radiology requests — 9 November 2006", which sets out how non LPSs requests will be handled.*

The MRT strikes of 10 to 20 November 2006 followed three strikes in September 2006. The contingency plan of November 2006 included the same information as the contingency plan of August 2006. In relation to the earlier strikes, Otago DHB provided an internal memorandum to all clinical staff, "Medical Radiation Technologist Strike Notice" from the Operations Manager, dated 5 September 2006, and a notice entitled, "Radiology Requests during MRT Strike" (undated, and recipients unstated).

The internal memorandum stated that agreement for life-preserving cover had been reached for the period between 12 and 15 September 2006, and that:

> "Radiology procedures including plain film x-rays, CT, MRI, DSA and ultrasound will be provided on an on-call basis only for life-preserving situations where all other avenues have been explored including referral to another provider, eg: patients with imminent respiratory, circulatory or neurological collapse.
>
> All referrals during the period of industrial action will be assessed and coordinated through the Radiology Consultant team."

The notice "Radiology Requests during MRT Strike" requested that "all clinical referrers identify on referrals to the Radiology Department those which they have determined as life-preserving" and that this "may require some discussion between the Radiology Consultant and referrer".

Response to provisional opinion

In response to my provisional opinion, Mr Brian Rousseau, Chief Executive Officer, Otago DHB, stated:

> "The foregoing has been discussed with [the] Chief Medical Officer, and [the] Operations Manager and Contingency Planner for the MRT industrial action.
>
> We have concluded that our understanding of some of the facts surrounding this circumstance is in conflict with your own, and with respect, we do not agree that the ODHB was in breach of the Code. …
>
> Compliance with our Understanding of the LPS Agreement
>
> We believe that the two experts you have used as advisors have come to quite differing views as to whether or not the decision point faced by [Dr C] constituted an LPS.
>
> We also note that point one of the *Agreement for the provision of life-preserving services between Otago DHB and APEX* [November 14–20 2006] states that triage 1 & 2 ED patients that involve LPS will be accepted given that all attempts to decant and or redirect will have been made. 'This includes patients with imminent respiratory, circulatory or neurological collapse or substantial risk of such collapse where radiological services are mandated for diagnosis or treatment'.
>
> Dr Geoffrey Robinson … interprets '*imminent neurological collapse or substantial risk of such where radiological services are mandated for*

diagnosis' as validation of a request for an MRI under the agreement and expecting it to be accepted.

However, we understand this clause to mean that all attempts to decant and/or redirect will have been made for this group [i.e. imminent neurological collapse] before LPS will be accepted. Dr Richard Frith interprets the clause similarly, and then states that if the scan had not shown a serious or progressive diagnosis then the ODHB would have likely been in breach of its agreement with APEX …

We believe that the central point is whether or not [Dr C] was adequately supported in his decision making through the contingency planning and communication that took place to make a decision consistent with our understanding of the rules of the LPS Agreement in real time, not with retrospective knowledge of the patient's diagnosis.

We believe that [Dr C] made the correct decision and was adequately trained and versed in the LPS criteria. This is validated by Dr Richard Frith's opinion. [Dr C] believed that in his clinical judgement the patient had had a cerebellar infarction and was not in imminent danger of deterioration of collapse. Cerebellar abscess was not part of the differential diagnosis.

[Mr A's] life was not considered to be in danger. Therefore we believe that the LPS criteria were not satisfied.

The Agreement required that a patient such as [Mr A] should be decanted and/or redirected if there was concern of imminent neurological collapse. As there was no available private MRI/CT facility in Dunedin during the weekend ([a radiology service]), [Mr A] would have had to be sent to Timaru for a scan but this was not considered necessary.

Such transfer had occurred with another patient who had a more acute presentation to his intracranial pathology than [Mr A's] presentation had been.

The decision was made when the patient had deteriorated and his Glasgow Coma Scale score had fallen to scan him under the LPS Agreement, and this was done.

<u>Planning for strike and information and guidance provided to staff</u>

We believe that there had been adequate planning for the strike and sufficient guidance for clinicians in regard to LPS. This is evidenced in the information already sent to you and further supported by the following which has not previously been made available to you. This was an omission on our behalf.

- [The Operations Manager and Contingency Planner] led contingency planning at the local level and also communicated nationally to ensure

consistency across DHBs in regard to all aspects of contingency planning and management of care processes during the strike.

- From the 30 October 2006 until the strike there had been daily contingency planning meetings, in most part chaired by [the Operations Manager and Contingency Planner], and attended variously by Group Managers, Service Managers, the Clinical Leader of Radiology, Clinical Director of Support Services, the Chief Medical Officer and the Chief Medical Officer Assistant, Nursing Directors and the Allied Health Director. The minutes of these meetings were widely disseminated and are enclosed.

- There were regular meetings at the unit level held by the Service managers with Senior Medical Officers to discuss issues that were unique to each particular service.

- On November 8 2006 a special meeting of the General Medical Staff was called and [the CMO] gave a presentation on the responsibilities of the DHB and responsibilities of the clinicians in regard to the strike …

- A memorandum of Emergency Department medical staff was sent out by [the ED Clinical Leader] …

In summary, we assert that [Mr A's] case exemplifies the risks associated with industrial action that involves LPS agreements that disrupt normal diagnostic decision making and clinical care processes. We however do not accept that the staff at the Otago DHB were not adequately informed or educated in regards to LPS criteria. We believe that [Dr C's] decision making in regard to the LPS criteria indicates he was well informed on the topic and in the interpretation of the criteria as confirmed by Dr Frith, your clinical advisor.

Dr Frith himself notes that [Mr A] could not be said to meet the LPS criteria prospectively. [The CMO] believes this is a central point, the patient only met the LPS criteria when he deteriorated in real time, and that clinical decisions are made in real time. That only using the *retrospectoscope* can it be said that the patient met LPS criteria.

We agree that this situation demonstrates how such arrangements as the LPS Agreement during this strike present clinicians with 'an unenviable moral dilemma', the DHB with a 'thorny legal dilemma', and that ultimately [Mr A] faced the 'risk of death from a situation completely out of his hands'. That it is hard to 'avoid the conclusion that the wrong party is in the dock in this investigation'.

We agree totally with your comment that this case 'highlights the incontrovertible fact that patient safety is jeopardised during strikes by health

professionals'. This is in direct contrast to claims made by APEX and is indeed the excuse used to allow such strike activity to proceed. …

We dispute that by following the legal processes required of us by our contemporaneous understanding of the Code of Good Faith for Public Health Sector and our LPS agreement we have breached the Code of Health and Disability Services Consumers' Rights, and respectfully ask that you reconsider such a conclusion.

We believe that this case raises a number of issues that require reconsideration of how LPS Agreements are formulated and determined through current legislation. It also raises the thorny issue of balancing rights of health service staff to strike with those of rights of patients, as there can be no guarantees of upholding patients' rights during strikes."

Code of Health and Disability Services Consumers' Rights

The following provisions of the Code of Health and Disability Services Consumers' Rights are relevant to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

(4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.
(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

CLAUSE 3

Provider Compliance

(1) A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.

Opinion: No Breach — Otago District Health Board

Introduction

This case highlights the vulnerability of patients and the dilemmas faced by clinicians and DHB management during a lawful strike by essential staff. The specific issue for determination is whether Otago DHB provided Mr A with services of an appropriate standard during the strike by medical radiation technologists (MRTs) in November 2006, but the broader issue is how the DHB and patients like Mr A came to be in such an impossible situation.

Relevant law

Participation in a strike is lawful if the strike relates to bargaining for a collective agreement under the Employment Relations Act 2000.[6] Under this Act, the Code of Good Faith for Public Health Sector (Code of Good Faith)[7] recognises the need of parties to commit to developing, maintaining, and providing high quality public health services, and to the safety of patients, and the promotion of productive employment relationships in the public health sector. It is binding on district health boards, their employees, and the employees' union representatives.

Employers have a general obligation to provide for patient safety during industrial action (clause 11 of the Code).[8] An employer must develop a contingency plan and take all reasonable and practicable steps to ensure that life-preserving services (LPSs) are provided during industrial action (clause 12(1)).[9] Clause 12(2) sets out the steps an employer must take in requesting assistance of members of the union to deliver LPSs.

Under clause 3 of the Code of Good Faith, "life-preserving services" means[10] —

(a) crisis intervention for the preservation of life;

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[6] Section 83 of the Employment Relations Act 2000 prescribes the conditions for a lawful strike related to collective bargaining; section 86 sets out when participation in a strike is unlawful.

[7] Schedule 1B of the Employment Relations Act 2000.

[8] Clause 11 of the Code of Good Faith states, under the heading '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."

[9] Clause 12(1) of the Code of Good Faith states, under the heading 'Contingency plans': "As 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."

[10] From 22 December 2006 the definition of "life-preserving services" in clause 3 of the Code of Good Faith was amended by the addition of the following paragraphs:

a) crisis intervention for the prevention of permanent disability;

b) care required for therapeutic services without which permanent disability would occur;

c) urgent diagnostic procedures required to obtain information on conditions that could potentially lead to permanent disability.

(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.

In *APEX v Capital and Coast District Health Board*,[11] the Employment Relations Authority confirmed that "it is necessary to take a very broad view of what constitutes life-preserving services under the Code of Good Faith" and noted that 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 and any agreement under the Code.

A DHB's legal obligation to ensure that services of an appropriate standard are provided to patients, in accordance with Right 4 of the Code of Health and Disability Consumers' Rights,[12] is not suspended during a strike — although the strike will naturally be a relevant circumstance to consider in determining whether a DHB's response was adequate.[13]

Otago DHB's preparation for strike
In preparing for the MRT strike commencing 10 November 2006, Otago DHB held daily contingency planning meetings from 30 October 2006. Regular meetings were held at the unit level by service managers with senior medical officers, and a special meeting of the general medical staff was held on 8 November 2006. The DHB notified clinical staff of the impending MRT strike, and that it had been agreed between the DHB and the APEX union that MRT members could provide LPSs as a last resort if specific criteria were met. Otago DHB's criteria for assessing radiology requests were the Code of Good Faith and the Agreement between Otago DHB and APEX, which included examples of situations for an LPS. The procedures for requesting LPSs from radiology services were set out in flow charts. This information was sent to clinical staff by the CMO as part of the "strike contingency information pack" on 9 November 2006, the day before the strike commenced.[14]

A key issue in this case is the understanding of clinical staff of the conditions and circumstances surrounding an LPS. Under clause 3(c) of the Code of Good Faith, LPSs mean "urgent diagnostic procedures required to obtain information on potentially

[11] *APEX v Capital and Coast District Health Board*, unreported, ERA, 17 July 2007, WA-98/07, Member Wood. The Authority noted that "… a decision … 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."

[12] Right 4(4) of the Code of Health and Disability Consumers' Rights recognises the ethical principle of "do no harm" or non-maleficence.

[13] See clause 3(1) of the Code of Health and Disability Services Consumers' Rights, providing a "reasonable actions in the circumstances" defence.

[14] This report does not seek to single out the CMO. However, as he had a key role in putting mechanisms in place for obtaining an LPS, his actions have been examined as part of the system under scrutiny.

life-threatening conditions".[15] I endorse Dr Robinson's comment that "at the crux of this matter is the apparent acceptance that an MRI head scan could not be requested or performed on the afternoon of Mr A's presentation when … there was clear recognition of the potential deterioration to a life-threatening state".

Dr Robinson queried the adequacy of information and guidance provided to Otago DHB clinical staff to enable them to provide an appropriate service during the strike. He was of the view that the CMO's email to medical staff "was not constructed in a way that would be regarded as a comprehensive strike contingency plan in itself". He commented on the absence of any reference to links to other information for clinicians about the contingency plans. There was no discussion on the interpretation of an LPS as defined in the Code of Good Faith, nor was the Code itself supplied to staff. Examples of situations for LPSs were given, but there was no suggestion that staff could discuss individual referrals with the radiologists. A notice from the earlier MRT strikes mentioned discussion between the radiologist and referrer about which referrals are life-preserving. However, in Dr Robinson's view, the information provided on 9 November 2006 did not appear sufficiently supportive or inviting of discussions by clinicians facing difficult decisions.

The CMO's "strike contingency information pack" was sent out by email on 9 November for a strike commencing the next day, 10 November (albeit nine days before Mr A's presentation). This meant that there was little time for clinical staff to acquaint themselves with the information and ask questions.

The CMO's notice "To All Medical Staff" stated that during the last MRT strike the DHB was considered to be in breach of the agreement, and that the consequence of being found in breach would be total withdrawal of services, including LPSs, which would put patients at even further risk. This statement may well have influenced Dr C in his decision-making on obtaining an MRI scan (discussed below). As Dr Frith commented, the statement put clinical staff in a dilemma. If a scan had been requested when Mr A was stable with a normal level of consciousness and no signs of raised intracranial pressure, and it had turned out not to be a progressive or serious diagnosis, the DHB may well have been found in breach of the Agreement, with the risk of LPSs being withheld for all other patients.[16]

Otago DHB submitted that Dr Robinson interpreted "imminent respiratory, circulatory or neurological collapse or substantial risk of such collapse where radiological services are mandated for diagnosis or treatment" in the Agreement as validation of a request

[15] The definition of LPS in clause 3 of the Code of Good Faith includes diagnostic procedures to obtain information on potentially life-threatening conditions (and since 22 December 2006, conditions that could potentially lead to permanent disability).

[16] The processes used by the district health boards have since been refined, and there is apparently now an understanding between the unions and district health boards that if an LPS request is made, it will be met at the time, and any disputes about interpretation will be dealt with after the fact.

for an MRI, expecting it to be accepted. I do not interpret Dr Robinson's advice in this manner. It appears from the Agreement that "all attempts to decant and/or redirect" had to be made before LPSs would be available upon request for triage 1 and triage 2 ED patients. However, this precondition is not required under clause 3(c) of the Code of Good Faith. The key issue should have been whether the requested radiology service was an urgent diagnostic procedure required to obtain information on a potentially life-threatening condition. If so, the radiology request was an LPS, and the next step should have been a discussion with the CMO. In my view, the precondition "all attempts to decant and/or redirect" imported an element of unnecessary complexity into the situation — particularly since in some cases Timaru was the nearest redirection point. Patient safety should not be put as risk where decanting and/or redirecting is unrealistic.

Otago DHB's response to Mr A's presentation

Mr A presented at Dunedin Hospital Emergency Department on Saturday morning 18 November 2006 with features suggestive of cerebellar dysfunction. There were no markers of an underlying infective process. At 4.40pm on 18 November Dr C informed Mr A that he needed an MRI scan to establish the pathology, but noted that a CT or MRI scan could not be done at Dunedin Hospital because of the MRT strike. Dr C considered that Mr A did not fit the criteria for an LPS. He did not discuss the situation with a radiologist or the CMO that day. It was not until 3.45pm the next day, after Mr A's condition deteriorated, that Dr C spoke to the CMO and gained authorisation for Mr A to have an MRI scan. The MRI revealed a bleed of the cerebellum, and Mr A underwent an urgent craniotomy with drainage of a large left cerebellar abscess.

Dr C was placed in the unenviable situation of having to determine whether Mr A met the criteria for an LPS during the MRT strike. My physician advisor, Dr Robinson, commented that the medical staff were faced with a patient who was not initially in a life-threatening clinical state, but with a recognised potential to deteriorate to a life-threatening situation. My neurology advisor, Dr Frith, acknowledged that in retrospect Mr A may have satisfied one of the criteria for an LPS set out in the Agreement (between Otago DHB and APEX). Mr A subsequently suffered severe neurological deterioration from his cerebellar abscess. I accept Dr Frith's advice that prospectively (i.e. at the time) it could not be said that Mr A met the criteria for an LPS set out in the Agreement. In my view, no criticism can be attached to Dr C for his treatment of Mr A.

Conclusion

Strikes in the health sector are exceptional and uncertain times. Patients are vulnerable because clinicians are not able to implement standard clinical practice. That is why it is critical that district health boards have in place an effective process for the provision of LPSs for the duration of a strike. Although there is potential to breach an agreement with the union, hospitals cannot allow patient safety to be jeopardised. In situations of delicate clinical decision-making that frequently arise during a strike, the district health board must ensure that patient safety is the paramount consideration. Staff must be

given clear, practical guidance and information about the contingency plans in place, including the names and contact details of relevant persons to contact.

The MRT strike placed Otago DHB in a very difficult position, and Dr C clearly felt constrained in providing clinical care to Mr A. I accept the DHB's submission that Mr A's case exemplifies the risks associated with strikes that involve agreements on LPSs, which disrupt normal diagnostic decision-making and clinical care processes. I also share Dr Robinson's concerns about the DHB's implementation of its strike contingency plan, particularly his reservations about the information and guidance provided to staff. However, I acknowledge the planning undertaken by the DHB at the local and national levels, the regular contingency planning meetings, the special meeting where the CMO discussed the responsibilities of the DHB and clinicians, and the "strike contingency information pack".

Otago DHB had an obligation to ensure that it provided services in a manner that minimised the potential harm to patients like Mr A, and to ensure that patients received well co-ordinated services during the MRT strike. However, a provider can only be expected to take "reasonable actions in the circumstances" prevailing at the time (see clause 3 of the HDC Code). On balance, in the exceptional circumstances of the strike, I consider that Otago DHB's response was reasonable, and that it did not breach the Code of Health and Disability Services Consumers' Rights.

Other comments

This case highlights the incontrovertible fact that patient safety is jeopardised during strikes by health professionals. The Code of Good Faith for Public Health Sector is a legal document that will inevitably give rise to disputes interpretation. It cannot be relied on as a safety net for patients. I note Otago DHB's comment that this case raises issues about how LPS agreements are formulated and determined through current legislation.

Mr A had a serious neurological disorder, which might have resulted in death or serious long-term disability. He did not qualify for an MRI scan because he did not appear to be at substantial risk of neurological collapse. If an MRI had been performed (as it would have been, but for the strike) on the day Mr A was admitted to hospital, his brain abscess would have been detected and neurosurgery performed immediately, rather than allowing him to deteriorate to a perilous state over the ensuing 24 hours. Patients do not need help *in retrospect* — they need help *prospectively*. They should not have to be "at death's door" before it is available. Routine radiologic and laboratory investigations are performed in normal clinical scenarios precisely in order to prevent life-threatening situations.

I endorse the comment of Dr Frith that the clinicians treating Mr A were placed "in an invidious and impossible position by a strike situation … completely beyond their control". Dr Robinson advised that the clinicians were in a moral dilemma, but also had a legal obligation to comply with the Code of Good Faith (and be adequately informed), and a duty to perform clinical assessment and diagnostic considerations, and closely monitor patients, seek opinions and advocate. The clinicians faced an unenviable moral dilemma; the DHB faced a thorny legal dilemma; but Mr A faced the risk of death from a situation completely out of his hands.

It is hard to avoid the conclusion that the wrong party is in the dock in this investigation. The point is well made by Mr A and Ms B in their letter of complaint:

> "… [O]ur purpose is not simply to voice a complaint, but to ensure that this sort of situation is not allowed to happen again. The surgical, medical and nursing staff that cared for [Mr A] at Dunedin Hospital [during and after surgery][17] were fantastic.
>
> The administrative process however, which determined whether [Mr A's] situation was life-preserving was far less than adequate. … Vital medical services such as radiographers/medical personnel should not be allowed to take strike action in such a form that puts lives at risk. Formulae should not determine whether lives are put at risk. If strikes are allowed to continue there will be deaths."

My recommendation below to the Minister of Health is made in the hope that steps will be taken to prevent a repeat of a similar situation, given the increasing number of strikes in the health sector.

Recommendations

I recommend that Otago District Health Board review its strike contingency planning and implementation in light of this report and advise the Health and Disability Commissioner by **30 September 2008** of any changes made to its processes.

I recommend that the Minister of Health review this report and consider what action could be taken to ensure better protection of patients during strikes.

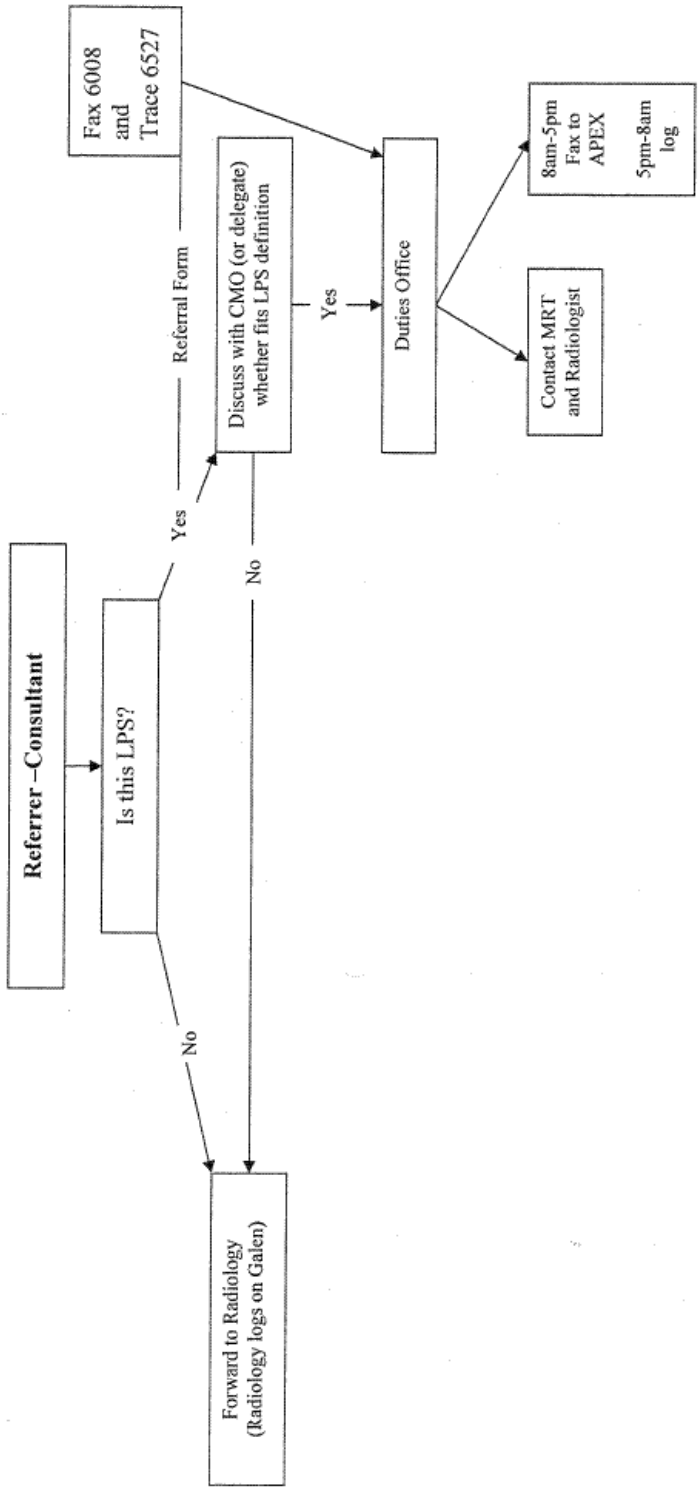
[17] Mr A and Ms B subsequently provided the bracketed words by way of clarification.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand.

- A copy of this report, with details identifying the parties removed, except Otago DHB and Dunedin Hospital, will be sent to the Minister of Health, the National Ethics Advisory Committee, the Director-General of Health, APEX, DHBNZ, the Association of Salaried Medical Specialists, the New Zealand Medical Association, the Royal Australasian College of Physicians, and the Royal Australian and New Zealand College of Radiologists, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix 1: Final LPS Process



Names have been removed (except Otago DHB/Dunedin Hospital) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix 2: Independent advice to Commissioner

Physician/systems advice
The following expert advice was obtained from Dr Geoffrey Robinson:

> "Thank you for seeking my opinion as an Independent Advisor on case number 07HDC05942. I have read and agreed to follow the Commissioner's guidelines for Independent Advisors.
>
> I have been asked to provide advice on whether the Otago District Health Board provided an appropriate standard of care to [Mr A], 07HDC05942.
>
> I have been provided with a summary of his clinical case as 'background' and supporting information.
>
> - Letter of complaint from [Mr A] and [Ms B] to the Commissioner, received 1 March 2007, marked with an 'A'. (Pages 1 to 6).
> - Letter to [the CMO] from [Dr E], dated 7 June 2007, marked with a 'B'. (Pages 7 to 19).
> - Notes taken during a telephone conversation with [Mr A] on 23 May 2007, marked with a 'C'. (Pages 20 and 21).
> - Response from ODHB with relevant documents relating to the MRT strike, received 4 July 2007, marked with a '0'. (Pages 22 to 85).
> - [Mr A]'s clinical records, marked with an 'E'. (Pages 86 to 185).
>
> …
>
> **Qualifications relevant to this advice:**
> I have been the Chief Medical Officer (CMO) of Capital & Coast District Health Board (CCDHB) since May 2005, and for two years prior to that the Clinical Director of Kenepuru Hospital. Whilst in post as the CMO I have been significantly involved with contingency planning for the National Resident Doctors (RMO) strike (June 2006), and a number of rolling strikes of CCDHB laboratory workers. During the latter I was involved in significant periods of 'gate-keeping' duties in which I opined on life-preserving laboratory tests. I have written an evaluation of the RMO strike as it affected CCDHB and I am an author of an article accepted for publication ('in-press') in Clinical Medicine on the RMO Strike. I have not been directly involved with contingency plans for medical radiation technologists as this has not affected CCDHB.
>
> I am a Fellow of the Royal Australasian College of Physicians (FRACP), and was on acute general medicine duties, Kenepuru Hospital, from 1981 until

becoming a CMO in May 2005. I continue to practise as a physician for 3/10 of my time. I have been an author of 70 peer-reviewed papers in medical journals.

Additional Information Request:

In the course of my initial perusal of supporting information, and in particular appendix 'D' (strike contingency documentation) it occurred to me that the November 2006 strikes were one of a number of strikes by MRTs in Otago DHB that year with others being the 12–15 September, 19–20 September, and 21–22 September (information from [the], National Strike Coordinator). Thus, it would be important with regard to the opinion sought for me to examine the November 2006 contingency plans in context with those of the preceding strikes.

Further information was requested from the Otago DHB about the earlier strikes and their contingency planning, and a response was received from the Otago DHB on 15 January 2008. I also asked for further information related to the November 2006 contingency plan (appendix 'D') as follows:

1. Emergency Department (page 70): What were the 'criteria for assessing radiology requests?'

2. Medical services (page 71): What was the 'agreed criteria in access to radiology?'

3. 3 November 2006 reference to produce a strike contingency plan information pack to those working: 'Did it happen and which staff received it?'

The clinical case:
I have read the summary, various correspondence and case notes of [Mr A] around which specific HDC questions to me have been generated.

I wish to make several overview comments, appreciating that the HDC has sought more refined views from others on the management of the case per se. [Mr A] had been moderately unwell with the history of headache, poor balance, unable to walk unaided, two falls, vomiting, altered speech and abnormal neurological examination, on a background of diabetes and hypertension.

A cerebellar lesion was suspected by the referring General Practitioner. In the Emergency Department [Mr A] went through a usual process of various assessments by the ED doctor, neurology registrar, and the Consultant Physician, [Dr C].

[Dr C] confirmed the likely cerebellar lesion and the propensity of such to 'expand' which could result in life-threatening deterioration. Thus the medical staff were faced with a patient not initially in a life-threatening clinical state but

with a recognised potential to deteriorate to a life-threatening situation. The need for brain neurological imaging, preferably an MRI scan, was clearly documented at 4:30 p.m. on 18 [November] 2006 and the patient/family informed of such. As an indication of the desirability of an MRI, an attempt was made to ascertain whether this could be done in a private radiological facility (patient had private insurance), but this was not available. The clinicians seemed accepting of the situation that an MRI could not be performed at that time because of the MRT strike and the fact that [Mr A's] condition was not immediately life-threatening. Admission with very close monitoring was decided as the appropriate management.

[Mr A] deteriorated the next day and when in extremis the MRI was requested under life-preserving criteria, and was immediately agreed by the gate keeper (Chief Medical Officer). I am not venturing a view as to the appropriateness of monitoring and clinical processes taken on 19 November 2006, which will be the purview of other advisers.

One of the issues at the crux of this matter is the apparent acceptance that an MRI head scan could not be requested or performed on the afternoon of [Mr A's] presentation when 'currently his life was not in jeopardy', however there was clear recognition of the potential for deterioration to a life-threatening state. This opinion would relate to the initial clinicians' understanding of the conditions and circumstances around life-preserving services. This in turn could relate to the effectiveness, and propagation of such information to clinicians under contingency planning, and the avenues open to clinicians on the availability to seek advice via radiology (eg agreed criteria for assessing radiology requests in the Emergency Department) or the gate keeper(s). I note no documented attempt to seek advice or discussion occurred on the afternoon of 18 November 2006.

Legal Framework:
At this point it is necessary to consider the definition of Life-Preserving Services contained in the Code of Good Faith for the Public Health Sector of the Employment Relations Act 2004 (clause 3 of schedule lB) which is the overarching guideline, and the basis of the contingency agreement with the union.

Under schedule lB Life-Preserving Provisions were:

(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.

This implies that it is reasonable to obtain diagnostic procedures required to obtain information on potentially life-threatening conditions.

The Agreement for the Provision of Life-Preserving Services between Otago DHB and Apex 14 November–20 November 2006 (appendix 'D', page 00028) notes that the DHB is requesting staff (MRTs) to cover essential services for LPS as per the Code of Good Faith, and then cites examples, one of which was 'imminent neurological collapse or substantial risk of such where radiological services are mandated for diagnosis or treatment'.

Personally I believe, acknowledging my possible bias from subsequent 'interpretation' of Life-preserving Services, that there was a case for the clinicians assessing [Mr A] initially to have considered requesting or discussing the case for an MRI with the gate-keeper, given the recognised risk of patients with cerebellar lesions deteriorating, and an expectation that a request would be approved under the code provisions and the 'Agreement' with Apex. I am aware from page 2, paragraph 5 of the letter from [Ms B] and [Mr A] that the consultant had accessed certain strike contingency documentation, but did not activate the LPS process (Appendix D page 32). There is nothing in what I have read to suggest that such a request for an MRI would have been rejected.

Strike Contingency Planning:
With this background I will explore specific questions posed by the HDC. This is a matter which needs to consider the iterative nature of the development of strike contingency plans across the Health Sector and DHBs over the last few years; the gradual acquisition of national and institutional knowledge, legal interpretation of legislation, and consolidation of advice from various significant bodies including the Medical Council, Health & Disability Commissioner, and New Zealand Medical Association.

It would seem important to note, as my memory serves, that a majority of this discussion followed shortly after the MRT strikes relevant to this investigation, and were around the time of the laboratory strikes in December 2006. Important events subsequent to the Dunedin MRT strike included Dr Court's interpretation of Life-preserving Services (including the definition, the individuality of a particular patient, the gate-keeper's functions and liability issues), the amendment to the Code of Good Faith to include permanent disability (18 December 2006), and various legal opinions which included discussion of the word 'potentially', and that Life-preserving Service agreements provide 'examples only' which are not constraining. Recent plans to retain optimally coordinated and sustainable national contingency planning via DHBNZ have been actioned, and acknowledge the importance of this issue and encompass institutional accumulated knowledge.

I have read the strike contingency plans and documentation (Nov 06) contained in Appendix D provided by the Otago DHB.

Following the request for supplementary information relating to the earlier MRT strikes (to put the November strike in context) I have seen the contingency plan of August 2006, which is the same as that of November 2006 as in appendix 'D'. I believe this is a generally 'fit for purpose document' with sound organizational key objectives, general principles and strategies. This also included a basis for departmental planning. The Contingency Plan addressed the approach to risks, communication strategies, patient transfers, deployment of staff / rosters, postponement of elective work and outpatient clinics, and media contact. This would have served as a basis for managers to address many of the issues raised by the MRT strikes, but it is not a document of use per se to clinicians.

The Contingency Plan did refer to material that would be seemingly useful to clinicians including 'daily updates to all staff' page 76, 'produce strike contingency information pack to hand to those working' page 81, and 'convene contingency meeting to provide those working with communication pack' page 84. I have not been provided with any information on the outcome of these intentions and it may be that these did not happen.

As mentioned earlier in this report I was interested to know about the development of specific criteria for assessing radiology requests (as in the ED service plan action point to 'agree criteria for accessing Radiology requests' — page 70, and the Medical service plan to 'agree criteria for LPS and access to radiology' page 71) The DHB advised 18 January 2008 that these were referring to the 'Code of Good Faith' and the 'Agreement between Apex and Otago DHB'. These were seemingly not developed further.

In the supplementary information provided on 15 January 2008 there is an information document for patients (page 48). This was developed prior to the first strike, and was presumably available to patients during subsequent ones. I am unsure if [Mr A] was given this but the tenor of this memorandum was conveyed to him by clinicians on 18 November 2006.

A further (undated) document from earlier MRT strikes 'Radiology requests during the MRT strike' was also included. It is not stated to whom and how this was sent. However, this document is noted because it acknowledges and possibly invites referrers to enter discussions with more senior staff when faced with difficult cases, and also comments on supporting clinical staff over decisions.

A further memorandum to clinical staff was issued on 5 September 2006, a week before the first strike. This included a fairly rudimentary paragraph on life-preserving cover. [I am aware from other correspondence ([Dr E] 07/07) that the agreement between the Otago DHB and Apex was circulated before the first strike.] The description of life-preserving cover does not include the wider definitions of the Code of Good Faith for clinician consideration, and is

restrictive in referring to 'patients with imminent respiratory, circulatory or neurological collapse' without further qualification.

I am not aware of other correspondence, communication with staff, or other contingency work from this time prior to the first strike, until the documentation of 9 November 2006, the day before the strikes of 10–14 November and 14–20 November 2006. This was by email from [the Chief Medical Officer], on the topic of the MRT strike. This email was sent to all medical staff including the clinical directors and clinical leaders (specified). It is difficult to gauge how many medical staff read their emails. I have some concern on the structure and lack of headings in this communication to medical staff. It addressed issues of compliance with the Union (and risks of non-compliance). It does refer to consultants needing to take life-preserving requests to the CMO, but is not inviting of discussion around clinical dilemmas. There is a final section on legal liability as it may affect clinicians, or more likely the DHB itself.

The second attachment is the agreement between Apex and the Otago DHB for this strike period. The third algorithm refers to non life-preserving services process, and the fourth diagram to life-preserving requests which specifically requires discussion with the CMO.

I have noted earlier in this section that there was a 3 November action (page 81) to produce a strike contingency information pack. It may be that [the CMO's] email was additional to other information as per the contingency plan, but I have not seen evidence of this.

I would like to have seen reference to the scheduled meeting (page 84 in the contingency plan) with senior clinicians (clinical directors and clinical leaders, other medical staff and senior nurses) whereby they would have had opportunity to discuss definitions, process, patient safety issues, or various legal matters.

Conclusions:

Having read all this material I have reached some conclusions with regard to the specific questions posed:

1. Did the District Health Board provide adequate information and guidance to staff to enable them to provide an appropriate service during the strike?

2. Was the information provided to staff in a timely manner?

3. Please comment on the adequacy of the contingency plan.

My view is that there are probable deficiencies in all three areas, and these are all below the expected standard to a minor degree. Without discussion with the Otago DHB staff involved, I am dependent on the documentation provided to draw the conclusions.

My reasons for this are principally that the Otago DHB did not appear to provide a comprehensive information pack or operational plan to clinicians clearly and fully setting out the range of issues expected.

Secondly, information from the Code of Faith regarding life-preserving services itself and an interpretation particularly around 'C' 'urgent diagnostic procedures required to obtain information on potentially life-threatening conditions' did not seem to be socialised to medical staff and there was thus a likely over-emphasis on the agreement between Apex and the Otago DHB per se. This could have led to inappropriate perceptions by staff on the actions to take around life-preserving services and requests for investigations.

The initial memorandum to clinical staff at the beginning of the first strike on 5 September 2006 was inadequate with regard to discussing life-preserving cover in a detailed way useful to clinicians.

Thirdly, although some earlier strike information to clinicians did mention contact and discussion with the gate-keeper (required by the algorithm page 32), the communications of 9 November 06 did not appear sufficiently supportive or inviting of discussions by clinicians facing difficult decisions as in the case of [Mr A].

Fourthly, the email from [the CMO] to medical staff was released the day before the November MRT strikes in question, and was thus arguably rather dislocated in the context of propagating a clear strike contingency plan. It was not constructed in a way that would be regarded as a comprehensive strike contingency plan in itself. There was no reference in the email of linkages to other information for clinicians that may have come from the contingency plans.

I cannot determine whether the strike contingency planning group produced the mentioned strike contingency information pack for clinicians, but I have not seen evidence of this.

Finally, I would like to have seen some confirmation that the meeting scheduled 8 Nov occurred.[18] Optimally there would have been meetings for medical staff with senior administrative clinicians and managers whereby a comprehensive

[18] Otago DHB subsequently confirmed that a special meeting of the General Medical Staff took place on 8 November 2006.

> strike planning document for clinicians could have been discussed and various issues raised. In retrospect, one of those that would have been important would have been Code of Faith 'C' regarding carrying out tests in patients with potentially life threatening conditions, such as [Mr A]."

Further advice
Dr Robinson provided the following further expert advice in relation to Otago DHB's response to the provisional opinion:

> "I have read the additional information provided by Otago DHB with regard to 'planning for strike and information and guidelines provided to staff' on page 3 of the letter of the 5th June 2008. I have read the Minutes of the Contingency Planning Meetings and the details addressed. I appreciate that these would have been circulated to senior management and clinical directors, and that it was likely that Departmental meetings occurred to discuss unique service issues, but this is difficult to evaluate. Overall I was concerned with generic organizational strike planning, its implementation, and information and guidance to staff.
>
> It was reassuring to see that generic medical and nursing staff meetings were arranged. I note [the CMO] addressed the strike issues at the General Medical Staff Meeting on the 8th November. It was not made clear about the attendance at this meeting. Other than this I do not believe that the Otago DHB response otherwise changes my previous advice. …
>
> Regarding the issue of compliance with understanding of the LPS Agreement, I have given my interpretation about the utilization of Life-Preserving Provisions in clause (c), which I believe is the base legal framework, as acknowledged in the Apex-DHB Agreement. Thus, I believed it reasonable to activate an LPS process given the clinician had appreciated the potential for the patient to deteriorate.
>
> …
>
> I think clinicians were in a moral dilemma but also face a legal obligation to work within the Code (and be informed adequately) and perform clinical assessment and diagnostic considerations and closely monitor patients, seek opinions and advocate."

Neurology advice
The following expert advice was obtained from Dr Richard Frith:

> "This report has been prepared at the request of the office of the Health and Disability Commissioner. I have read and agree to follow the Commissioner's guidelines for independent advisers.
>
> I am a neurologist in clinical practice in Auckland, with appointments at Auckland City Hospital and private practice. I trained in neurology at Auckland

Hospital and received the Fellowship of the Royal Australian College of Physicians (Internal Medicine, in Neurology), in 1983. I subsequently held a fellowship position at the Mayo Clinic, Rochester, Minnesota, United States of America, prior to returning in 1985 to a position as neurologist and clinical neurophysiologist, Auckland Hospital. My clinical practice since 1985 has been as a clinical neurologist and clinical neurophysiologist. In addition to full-time clinical practice I have held a number of roles in the Auckland District Health Board organisation including Clinical Director of Neurology (1992–1999), Clinical Leader of Medical Services Auckland Hospital (2000–2002), and I continue with a number of roles including membership of the Clinical Board, Auckland District Health Board and Chair of the Auckland District Health Board Charitable Trust.

The referral instructions from the Commissioner are as below.

Purpose:
To provide independent expert advice about whether Otago District Health Board provided an appropriate standard of care to [Mr A].

Background:
On 9 November 2006 Otago District Health Board (ODHB/the Board) management sent an email to all clinical directors to inform them of the criteria for the provision of radiological service during the Board's medical radiation technologists (MRT) ten day strike. The strike was to start on 10 November 2006. The medical staff were informed that during this period 'only Life-preserving Services (LPS) will be available'. The agreement between Otago DHB and APEX was:

> 'The DHB is requesting staff to cover essential services for LPSs as per the code of good faith for the public health sector. Examples of such situations would include:
>
> 1. Triage 1 and Triage 2 ED patients that involve LPS will be accepted given that all attempts to decant and/or redirect will have been made. This includes patients with imminent respiratory, circulatory or neurological collapse or substantial risk of such collapse where radiological services are mandated for diagnosis or treatment (i.e. clinical diagnosis or alternative mechanisms for diagnosis or treatment are not available).'

At 11am on 18 November 2006 [Mr A] presented at the Urgent Doctors after hours clinic with a history of headaches, nausea and a four day-old onset of ataxia. He had a background history of diet controlled Type 2 diabetes, hypertension and hyperlipidaemia. His GP had treated him for the previous two days with an antiemetic for suspected labyrinthitis. [Mr A] was referred to Dunedin Hospital Emergency Department (ED).

[Mr A] was admitted to ED at midday and underwent the same neurological testing as performed by the Urgent Doctors. At 4pm he was seen by neurologist [Dr C] who considered that [Ms B] had either an intracerebellar haemorrhage and/or a cerebellar infarction. [Dr C] advised [Mr A] that he needed an MRI head scan, informed him of the MRT strike and recommended that he try to have the scan at [the private hospital]. However, at 5pm [Mr A] was advised that the MRI equipment at [the private hospital] was 'out of action'.

[Mr A] was admitted to the Dunedin Hospital neurological ward.

At 8 on 18 November, the on-call neurology house surgeon was called to see [Mr A] as his nausea was causing concern. [Mr A] was seen by the house surgeon at 10.18pm and found to be clinically stable.

At 10.30am on 19 November, the nursing staff were concerned about [Mr A's] Glasgow Coma Scale (GCS) and called the neurology registrar to review him. The registrar considered that [Mr A] was stable but informed the ward staff that if there was a significant deterioration in [Mr A's] condition he was to be considered for a 'life saving head scan'.

At 11.15am [Mr A] sustained a fall on the ward.

At 2.40pm he was found to be incontinent of urine and to have fluctuating levels of consciousness. [Dr C] was called at 3.30pm. [Dr C] reviewed [Mr A] and noted that further management was dependent on obtaining a scan. [Dr C] called [the] Chief Medical Officer and discussed [Mr A's] case with him. [The CMO] authorised the scan.

The scan, performed at 6pm, showed an unusual left cerebellar haemorrhage. [Dr C] called neurosurgeon [Dr D] to discuss the MRI findings as he believed [Mr A] had a tumour or abscess. [Dr D organised an urgent craniotomy.

Following the craniotomy [Mr A] was transferred, at 9.30pm, to the Intensive Care Unit (ICU) and started on intravenous antibiotics. [Mr A] had a follow-up CT scan on 20 November and was transferred to the neurology high dependency unit on 22 November. He was discharged home on 13 December 2006.

Complaint:
Whether Otago District Health Board provided [Mr A] with services of an appropriate standard on 18 and 19 November 2006.

Supporting Information:

- Letter of complaint from [Mr A] and [Ms B] to the Commissioner, received 1 March 2007, marked with an 'A'. (Pages 1 to 6).

- Correspondence from [Dr E], from 28 November 2006 to 7 June 2007, re his concerns about the provision of services during the MRT strike, marked with a 'B'. (Pages 7 to 12).
- Notes taken during a telephone conversation with [Mr A] on 23 May 2007, marked with a 'C'. (Pages l3 & 14).
- Response from ODHB with relevant documents relating to the MRT strike and clinical records, received 4 July 2007, marked with a 'D', (Pages 15 to 78).

…

For the purposes of preparation of this report I have been provided with photocopied information including various medical reports provided by the Otago District Health Board and other relevant correspondence including correspondence generated by the Chief Medical Officer in preparation for the radiographers' strike. In addition I requested copies of all handwritten and other clinical notes relating to the patient's admission to hospital and his subsequent care and these were provided by the office of the Heath and Disability Commissioner. I have not reviewed any radiological studies, but the descriptions of the radiology are adequate for the preparation of this report.

Factual summary
The report written by [Dr C], Consultant Neurologist, Otago District Health Board, I believe contains an accurate account of the patient's illness. This has been confirmed by my review of the written case records, and other clinical information provided in various reports supplied by the Commissioner's office.

In summary, the patient was admitted to Dunedin Hospital on 18 November 2006 for investigation and management of an illness which had started approximately one week prior. Symptoms included headache, nausea, vomiting and unsteadiness while walking. When he was initially examined in the Emergency Department at Dunedin Hospital the pertinent clinical features included a normal body temperature and normal heart rate. The records suggest that he was alert and orientated. The neurological examination did not report any focal neurological signs. The ankle reflexes were absent, but this was attributed to a possible peripheral neuropathy related to the patient's known diabetes mellitus.

The clinicians involved in his care considered a number of neurological explanations for his symptoms and it was recognised at an early stage that these included a lesion of the cerebellum (the balancing organ of the brain) with potential pathologies including a stroke. At the time of his first clinical examination there was no evidence for raised intracranial pressure (in that he was alert and there was no papilloedema).

The patient was first examined by a consultant neurologist on the afternoon of 18 November, where [Dr C] confirmed the presence of clinical signs suggesting disease of the cerebellum. The lack of fever was considered evidence against any underlying infection such as an abscess or meningitis.

[Dr C's] handwritten records at 4:30pm on 18 November 2006 indicate that the patient was informed that he required a magnetic resonance imaging scan to establish the exact nature of the pathology in the cerebellum. [Dr C] considered that the problem was either an intracerebellar haemorrhage or a cerebellar infarction and he considered possible causes might include dissection of the vertebral or basilar arteries.

[Dr C] considered that the patient's life was not in jeopardy, but that with expansion of a haemorrhage and occlusion of the fourth ventricle this could result in an acute situation which would be life-threatening.

[Dr C] recorded that either a CT scan or MRI scan was indicated with this condition, but due to the strike of the radiographers, this procedure could not be performed. [Dr C] informed the patient and his [partner] of the situation and an attempt was made to obtain a scan privately. [Dr C] recorded that if this was not possible, the patient's condition would be monitored closely and if there was any change in his condition, particularly development of any life-threatening situation, steps would be taken to immediately obtain the necessary permission for scanning.

The patient was admitted to the Neurology Ward where regular neurological observations were made and recorded. On the evening of 18 November it was recorded that the Glasgow Coma Score was normal at 15 out of 15.

The next day, 19 November 2006, the nurses recorded and reported concern about the patient's level of consciousness. He was examined by the neurology registrar, [Dr G], who recorded that the Glasgow Coma Score had been stable and that the patient was able to recount events clearly. His speech was slurred, but it was considered that this had improved since earlier in the admission. The formal recordings indicate that the Glasgow Coma Score remained at 15 out of 15, and the pulse and blood pressure were normal. The patient had been reviewed earlier that morning by [Dr C], Consultant Neurologist.

While the clinicians remained concerned that there was significant intracranial pathology, there were no signs to suggest raised intracranial pressure such as elevated blood pressure, slowed pulse, or papilloedema.

Later on the morning of 19 November the patient fell and this included an injury to the head with bruising over the right forehead and the nose. Subsequently observations showed that he was drowsy; his speech was reported to be slurred but no different from previously.

On the afternoon of 19 November the patient was incontinent of urine, he was restless and disorientated and he was again reviewed by the neurology registrar, who recorded a reduction in the Glasgow Coma Score to 12 out of 15.

[Dr C] was called and he reviewed the patient at 1540 hours. [Dr C]' handwritten records indicate that the patient had become more confused and drowsy, had been incontinent of urine, was more unsteady on his feet and had developed confusion. He recorded a further deterioration in the level of consciousness in the last hour.

[Dr C] considered this deterioration was likely due to an intracerebellar haemorrhage with compression of the fourth ventricle and progressively increasing intracranial pressure. He considered that this was a life-threatening situation which could require urgent neurosurgical intervention.

[Dr C] recorded that further management of the patient was dependent on obtaining immediate brain imaging and he obtained permission from [the] Chief Medical Officer, for the scan to be performed.

The MR scan indicated pathology in the cerebellum with an unusual appearance and [Mr A] was taken immediately to the neurosurgical operating theatre, where [Mr D], neurosurgeon, performed a posterior fossa craniectomy with drainage of a large left cerebellar hemisphere abscess. Laboratory studies indicated a mixed growth of infection. Postoperatively the patient was managed in an appropriate way including a period of time in Intensive Care and subsequently in the neurology ward. He had a prolonged, and appropriate, course of antibiotic therapy. The subsequent records, both inpatient and outpatient, indicate that the patient made a satisfactory recovery.

In summary, this patient presented with a progressive neurological disorder which turned out to be a cerebellar abscess. This was a serious and life-threatening disorder. While the patient eventually made a satisfactory recovery, there is no doubt that his life was seriously threatened and there was potential for death or residual serious disability.

With respect to the specific questions asked by the Commissioner:

1. *What is the appropriate treatment for a patient presenting with [Mr A's] clinical picture?*

The appropriate investigation is CT brain scanning or MR scanning as soon as possible followed by appropriate therapy, either medical or surgical. As the responsible clinicians recognised, the scan should have been performed at the time of admission.

2. *Were there any other treatment options that could have been considered in the circumstances and were all the possibilities explored?*

The responsible clinicians recognised exactly the clinical situation, and the seriousness of the situation. They made the most accurate clinical diagnosis that could be made in the circumstances. They realised the need for immediate scanning and realised the consequences of progressive deterioration should there be an expanding intracranial lesion. The clinicians attempted to obtain a private scan to circumvent the limitations placed by the radiographers' strike, but this was not possible because, apparently, the private scanner was out of action. In these circumstances, and the absence of availability of public hospital scanning, there was no alternative but to continue with careful clinical observation.

3. *Was the monitoring of [Mr A's] condition appropriate?*

The patient had careful and close monitoring of his neurological state. This included regular assessment of his neurological condition including regular recordings of the Glasgow Coma Score. The nursing staff recognised a change in his state, and appropriately called the registrar, on the morning of 19 November, to review the situation. Subsequently, after the patient's fall, again it was recognised that there was deterioration in the patient's state, both from general observation and from accurate and careful monitoring. This included an observation that there was a reduction in the Glasgow Coma Score and the development of confusion.

4. *In your opinion, when did [Mr A's] qualify for LPS?*

This will be discussed further below, but using the guidelines provided by the Chief Medical Officer, it is my opinion that this patient did not qualify for a 'life-preserving scan' until the time of the deterioration on the afternoon of 19 November 2006. In other words, as soon as he satisfied the requirements, he was reviewed by the responsible consultant neurologist and immediate efforts were made to obtain a scan and then to proceed to neurosurgical intervention.

5. *Were the assessments of his condition and the decisions made regarding his treatment options reasonable?*

It is my opinion that the neurological assessment was accurate and appropriate. The clinicians were aware of the seriousness of the situation and [Dr C], in particular, clearly outlined his concerns about the potential for deterioration and that in that circumstance an urgent scan would be justifiable. This is particularly the case when there was clear deterioration on the 19th of November 2006. In my opinion other neurologists would consider that the conduct of [Dr C] and his team was appropriate, given the extraordinary

circumstances beyond the control of the clinicians related to the radiographers' strike.

I wish to make additional comments on two matters.

1. This patient clearly, in retrospect, had a serious neurological disorder which might have resulted in death or serious long-term disability. There is no doubt in my opinion that if a scan had been performed earlier that this patient would have proceeded to neurosurgical intervention at an earlier time and would have started on antibiotic therapy earlier than he did. However, there were no specific features to indicate to the clinicians that this patient might have a cerebellar abscess. There was no fever, and no other particular markers to suggest that diagnosis.

2. The pertinent and most important feature of this case is that the patient presented to Dunedin Hospital at the time of the radiographers' strike. This strike produced, in my opinion, an extraordinary threat to patient safety and to the ability of clinicians to be able to practise an appropriate standard of medicine. Of particular relevance are the instructions to the medical staff written by [the Chief Medical Officer] prior to the strike. A copy of the directive was provided by the office of the Health and Disability Commissioner. In summary, [the CMO] wrote to the medical staff indicating that there would be a 10 day strike by radiographers starting Friday 10 November 2006. He indicated that during this period only 'life-preserving services' would be available. He included a copy of the legally binding document which was an agreement between the union and the Otago District Health Board.

[The CMO] indicated to medical staff that during a previous radiography strike it was considered that the Otago District Health Board was in breach, presumably on account of requesting an investigation which was not 'life-preserving' and that the District Health Board was taken to task by the union through their barrister. The threat was that if this breach occurred again, there would be a total withdrawal of all radiography services including life-preserving services.

[The CMO] indicated that clinicians would have to do the best they could in the circumstances, but that to breach the agreement would be putting patients at 'even further risk'.

[The CMO] indicated that patients should be fully informed of the situation (in this case [Dr C] recorded in the records that he had informed the patient and his [partner] of the situation and that under usual circumstances a scan would have been performed on the day of admission). [The CMO] gave a series of instructions about the management of referrals for radiology services during the

period of the strike. This included an opinion from [the] Otago District Health Board solicitors.

I have read the agreement between Otago District Health Board and the radiographers' union dated 5 November 2006. This comprehensive document makes it quite clear that in the Emergency Department patients with serious clinical condition could be considered for life-preserving services only after all attempts to 'decant and/or redirect' had been made. The definition included patients with 'imminent respiratory, circulatory or neurological collapse or subsequent risk of such collapse where radiological services are mandated for diagnosis or treatment'. Further in the document is the definition of the patients who could not be transferred and might be considered for life-preserving services and these, from the neurological point of view, including those with 'immediately impending coma (such as in the case of coning)'. The document then gives a description of the appropriate process.

In retrospect this patient might have satisfied one of the criteria for 'life-preserving services', in that he subsequently did develop a severe neurological deterioration and in retrospect radiological services were necessary for appropriate diagnosis and treatment. While it is easy to reach this conclusion retrospectively, prospectively my belief is that had a scan been requested for the patient when he was stable, had a normal level of consciousness and had no signs of raised intracranial pressure, and if that scan had not shown a progressive or serious diagnosis, then the Otago District Health Board would very likely have been found in breach of its agreement, and the risk was that life-preserving services would have been withheld for all other patients. It is my opinion that it was not until the patient's deterioration on 19 November 2006 that it became clear that he had a progressive intracranial lesion that required urgent investigation and treatment. It is important to emphasise that the clinical judgments made in the context of this radiographers' strike were made 'prospectively' with the information about the patient at the time being the only information that could be used, while we are in the position of being able to make judgments retrospectively when we know what happened with the patient.

While my opinion has been requested relating to specific aspects of the care provided to this individual patient, it is important to note that this is a circumstance where clinicians have been placed in an invidious and impossible position by a strike situation which is completely beyond their control. The office of the Health and Disability Commissioner provided me with a number of copies of correspondence including letters of concern expressed by other clinicians at Otago District Health Board about the seriousness of the situation with respect to lack of radiological services during the period of the strike and the fact that the strike resulted in serious consequences for other patients in addition to this particular case. In my opinion this situation should not arise in a health care setting. While the Health and Disability Commissioner might be

> required to opine only on this particular case, there would be merit in the office taking a broader view about the consequences of strike action on care for patients, and the impossible situation such strikes create for caring clinicians."

Further advice

Dr Frith provided the following further expert advice following Otago DHB's response to the provisional opinion:

> "Clearly there needs to be a decision about whether or not ODHB appropriately planned for the strike — in my view [Dr C] had a clear view of the issues and acted entirely according to them. I still contend that if the scan had been obtained, and had it been normal or shown a non-progressive lesion, that ODHB would have been found in breach of the agreement with the union for LPS with adverse consequences for subsequent patients.
>
> I would hope the major issue remains the risk to patients and staff as a consequence of strike action by health care professionals. …"