Appendix 1 and 1a

HSRA LPS project 2011 (finalised in 2012)

- LPS guidelines for SMO
- Contingency Planning overview

Development of the LPS Contingency Planning document and Clinical Guidelines has been agreed to by all HSRA parties. The Clinical Guidelines have been developed by HSRA parties to assist employers implement the Public Health Sector Code of Good Faith which is the substantive document establishing the process by which employers ensure patient safety during industrial action.
Provision of Life Preserving Services
Guidelines for SMOs during strikes by other Health Care Employees

Introduction

Under New Zealand employment law, as a general rule, strikes and lockouts are permitted, subject to a number of limits relating to the underlying purpose of the industrial action; the notice that may be required and the provisions of any Code of Good Faith that may exist for the particular sector.

Strikes and lockouts are defined in Part 8 of the Employment Relations Act 2000, which also sets out the circumstances when they will be lawful or unlawful.

The public health sector has its own Code of Good Faith, set out in Schedule 1B of the Act.

Clause 11 of the Code of Good Faith imposes a general obligation on employers to provide for patient safety during industrial action. Specifically, the clause requires:

*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.*

The Code also sets out the requirements for “contingency planning” in the health sector when notice of a strike or lockout has been given. The “contingency plan” must take all reasonable and practicable steps to ensure that the employer can provide life preserving services if the threatened industrial action goes ahead.

These guidelines offer advice to senior medical practitioners about what is meant by “life preserving services” and what level of care, treatment and testing they may confidently provide or access on behalf of a patient during a period of industrial action.

In addition to the legislative framework, senior medical and dental practitioners must also give regard to other important considerations:

- The doctor’s over-riding ethical and professional duty to their patient;
- As an independent practitioner, each doctor is responsible and accountable for the clinical decisions they make in respect of each patient, whether it was “to treat” or “to not treat”;
- A senior vocationally registered medical practitioner will not generally be told by their employer how to treat, when to treat or not to treat a particular patient although they may be asked for an explanation of decisions made.

Although the doctor may be called upon to justify their decision to order a test or commence treatment under the *life preserving services* regime, this will be after the event and neither the law nor common sense requires the doctor to seek permission beforehand from either their employer or the union whose members have taken the industrial action (access to LPS services will already have been agreed in the LPS agreement negotiated following the receipt of the strike notice) However it may well be necessary, and prudent, to consult with colleagues where there are limited available resources or where doubt about the possible course of action exists. It is reasonable to expect that the employer will have made such access to colleagues available for you through the contingency planning.
Definition of Life Preserving Services (“LPS”)

The Health Sector Code of Good Faith (Schedule 1B of the Act) defines Life Preserving Services ("LPS") as:

- crisis intervention for the preservation of life:
- care required for therapeutic services without which life would be jeopardised:
- urgent diagnostic procedures required to obtain information on potentially life-threatening conditions:
- crisis intervention for the prevention of permanent disability:
- care required for therapeutic services without which permanent disability would occur:
- urgent diagnostic procedures required to obtain information on conditions that could potentially lead to permanent disability

The Preservation of Life

The preservation of life requires consideration of two equally important matters: “Will the patient die or is the patient likely to die if they do not receive (1) a particular service at (2) a particular time?”

Examples:

1. Patient electively needs cancer surgically removed, but staff on strike; agreed that cancer needs removal to avoid death, but as the strike is for only one day there is no realistic prospect of harm by waiting another day; therefore does not meet the LPS test.

2. However, an acutely obstructing colon cancer with peritonism does require surgery urgently; therefore meets the LPS test.

3. Patient has compound femoral fracture, but MRTs on strike; fracture needs fixing; orthopaedic service needs x-rays and patient’s risk of mortality greatly increases with any delay; therefore meets the LPS test.

It is important for clinicians to understand that their request for a service under the LPS Agreement may be challenged. However such a challenge will be resolved after the event and will not interfere with the immediate need to treat the patient in question. It should also be noted that it is the employer who has to face the challenge although they may call upon the clinician to give evidence and explain the rationale for their request for services under the LPS Agreement.

Service without which life could be jeopardised

Under the Code of Good Faith the threshold for LPS may simply be the clinician’s properly based belief of the existence of a potentially life-threatening condition. Provided the clinician acts in good faith and genuinely believes that particular test (or procedure) is required to diagnose or exclude a life threatening condition, the request for the LPS will be justified.

Note: Diagnostic tests include exploratory operations or procedures.
However if the clinician requests the LPS without having a genuine belief of an imminent threat to life, the clinician may later be held to have acted in bad faith, leaving the DHB (but not the clinician) exposed to possible legal challenge before the Employment Relations Authority or Court.

**Permanent Disability**

This is an ill-defined and open issue, with no case law to offer guidance. It therefore becomes a matter of clinical judgment, leaving the treating clinician to assess the nature and extent of the clinical risk. Nor is “disability” defined in the Code and clinicians are left to make their own assessment based on the closely inter-related concepts of “structure and function”.

It should also be noted that the concept of the “prevention of permanent disability” involves two separate and distinct processes - diagnosis followed by treatment.

**Diagnostic Procedures**

Under its definition, Life Preserving Services include:

“urgent diagnostic procedures required to obtain information on conditions that could potentially lead to permanent disability”

Note that “urgent” is not defined, nor is “potentially” and once again it remains a matter of clinical judgment to assess the nuances of a particular presentation against the potential risk of permanent disability in each case.

Clinicians may reasonably request appropriate diagnostic tests or procedures, for any presentation where in the clinician’s judgement, a delay in diagnosis could potentially lead to a permanent disability. A radiology report, for example, would be reasonable in the case of a suspected fracture, pneumonia or bowel obstruction, provided of course there was a reasonable clinical basis for that suspicion.

Doctors will be all too well aware that they are just as likely to be criticised (e.g. by the Health and Disability Commissioner), for not ordering a test that might confirm a diagnosis than for ordering one that was subsequently found not to support the risk of permanent disability.

**Care or Treatment**

The definition of Life Preserving Services affords the treating clinician considerable flexibility and includes:

“care required for therapeutic services without which permanent disability would occur”

“Care” in this context relates to the therapeutic side of things and in the case of an MRT strike, might include anything done as part of delivering a “cure” or a “therapy” e.g. post-reduction x-rays, intra-operative image intensification, a chest x-ray after CVL insertion etc.
But Be Aware....

During periods of industrial action, it would be wrong to assume it was “just business as usual” in the delivery of acute care; that is not the case. The clinician’s right to order a test, procedure or treatment under the life preserving services regime exists only if there is no acceptable alternative course available that would not expose the patient to life-threatening risk or permanent disability.

Clinicians should recall the earlier two-part question: (a) what is needed, and (b) when is it needed?

If the requested intervention, (treatment, test or procedure) could be delayed until a non-striking employee became available, would that put the patient at a realistic risk of death or permanent disability?

Example:

1. Clinically closed fracture of forearm; no neuro-vascular compromise; skin good etc; presents at 0500 hours. Is there really a realistic risk of permanent disability if the x-ray needed to diagnose the problem is delayed three hours, until 0800 hours when the non-union MRT arrives?

2. Similarly when it comes to treatment, must this case (that will require an x-ray as part of the treatment) be done during the strike period under LPS or might the treatment be safely delayed until the non-Union MRT arrives?

In determining whether there might be an acceptable alternative to the LPS that would otherwise be ordered, a clinician will need to consider the following:

1. Would it be reasonable and safe to refer the patient for treatment, including a diagnostic test, from a provider whose employees are not on strike?

2. Is an alternative treatment option available? Is the alternative acceptable and therefore used first? For example: in some surgical cases there may be a non-operative or a delayed operative approach that might deliver a perfectly acceptable and successful outcome. In such cases, it would be difficult to justify a request under the LPS agreement.

Remember

At all times you are considering the situation as it relates to the particular patient you are assessing at the time. Based on that assessment at that time you will make a decision regarding options, what action is required and then you will document the rationale for the management plan chosen. It is reasonable to expect that any decision made during a period of industrial action is well documented in the patient’s clinical record.