IN THE EMPLOYMENT RELATIONS AUTHORITY
CHRISTCHURCH

[2017] NZERA Christchurch 204
5627656

	BETWEEN	KERREN GLASSON Applicant
	AND	SOUTHERN DISTRICT HEALTH BOARD Respondent

Member of Authority:	Christine Hickey
Representatives:	Bill Manning, Counsel for the Applicant Peter Churchman QC and Cassandra Kenworthy, Counsel for the Respondent
Investigation meeting:	24 & 25 November 2016 (Invercargill), 21 December 2016 (by telephone) and 29 August 2017 (Christchurch)
	Submissions received on 25 November and 21 December 2016 and 29 August 2017
Determination:	30 November 2017

DETERMINATION OF THE AUTHORITY

A. The APEX & South of Auckland District Health Board Sonographers Collective Agreement covers Kerren Glasson's work.

B. The parties must attend mediation to resolve the issue of how much money the Southern District Health Board owes Kerren Glasson.

C. Costs are reserved.

Employment relationship problem

[1] Kerren Glasson works at Southland Hospital, Invercargill, and is employed by the Southern District Health Board (the SDHB). Since 6 August 2009, her job title has been Specialist Technologist – Echocardiography.

[2] Ms Glasson has been a member of the Association of the Professionals and Executive Employees (APEX), which is a union, since 2004 or 2005.

[3] APEX has two relevant collective agreements with multiple District Health Boards, including the SDHB. The first multi-employer collective agreement (MECA) covers the employment of Clinical Physiologists, Clinical Physiology Technicians and others (the Physiologists MECA). The second MECA covers the employment of South of Auckland Sonographers (the Sonographers MECA).

[4] Ms Glasson has been employed under the Physiologists MECA since 2007, and is paid in line with that MECA. Prior to 2007, she was employed under the Cardiopulmonary Technologists/Scientists/Technicians collective agreement.

[5] On 6 May 2013, Ms Glasson requested the SDHB to transfer her to the coverage of the Sonographers MECA, under which she would be paid at a higher rate.

[6] By letter dated 1 July 2013, the SDHB declined her request. APEX has been assisting Ms Glasson in her desire to be transferred to the Sonographers MECA but the SDHB has declined APEX's requests.

[7] Ms Glasson seeks a determination that her work is covered by the Sonographers MECA, and has been since her first request on 6 May 2013.

[8] She also seeks an order that the SDHB should pay her wage arrears she would have received since 6 May 2013 had it accepted then that her work was covered by the Sonographers MECA.

[9] Ms Glasson seeks interest on any wage arrears and costs.

[10] The SDHB says that Ms Glasson is employed as a Cardiac Physiologist and therefore, her work is covered by the Physiologists MECA, and not the Sonographers MECA.

[11] The parties agree that the terms echocardiography and cardiac sonography have the same meaning.

[12] This determination will resolve the issue of which MECA covers Ms Glasson's work. If I find she should have been covered under the Sonographers MECA and establish a start date for that, before ordering what amount the SDHB owes Ms Glasson, I will send the parties to mediation in the hope they can agree on the amount of wages owed.

Ms Glasson's employment and qualifications

[13] Ms Glasson was initially employed by the Southland District Heath Board, the SDHB's predecessor, in December 1987 as a trainee Medical Technician.

[14] In 1993, she began practical training in cardiac ultrasound. In April 1994, after she had met the requirements of the New Zealand Society for Cardiopulmonary Technology, she was appointed as a Senior Medical Technician. Such a technician is now known as a Senior Clinical Technologist.

[15] In 2005, Ms Glasson was made Specialist Medical Technologist, although her core duties did not change. She was in sole charge of the cardiac ultrasound services with the majority of procedures she undertook being cardiac ultrasounds. She also had responsibility for performing respiratory investigations.

[16] On 11 November 2007, Ms Glasson was awarded the Diploma of Medical Ultrasound (Cardiac Scope), or DMU. This qualification is awarded by the Australasian Society for Ultrasound in Medicine (ASUM). It is a post-graduate qualification that is approved by both the Clinical Physiologists Registration Board and the Medical Radiation Technologists Board.

[17] On 6 August 2009, Ms Glasson signed a new position description. Her title was changed to Specialist Technologist – Echocardiography. This position description is the most up to date one. It provides that Ms Glasson is:

> To supervise the provision of an echocardiography service which operates in a safe and professional manner for the welfare of the patient.

[18] Her specific areas of responsibility include to:

- Perform cardiac ultrasound (echocardiography/echo procedures).
- Provide a robust cardiac ultrasound service.
- Provide a robust training and development programme for cardiac ultrasound.
- Provide a robust quality assurance programme for cardiac ultrasound.
- Maintain own professional competence and development.
- Perform such other duties as may be reasonably required by the Manager, Diagnostic Testing.

[19] There is no mention of respiratory investigations in the latest position description because Ms Glasson was no longer required to undertake these. She has not undertaken respiratory physiological procedures since August 2009. However, at that time she still performed some cardiac physiology testing, specifically one four-hour session of exercise tolerance tests and between 5 and 10 electrocardiograms per week.

[20] The 2009 position description remains current. It requires Ms Glasson to retain registration and hold an annual practising certificate (APC) with the Clinical Physiologists Registration Board (CPRB). She has been registered with the CPRB since 1999. The SDHB pays for the cost of her registration and her APC.

[21] Clinical physiology is not a field that the Health Practitioners Competence Assurance Act 2003 (the HPCA Act) regulates. Therefore, the CPRB is a voluntary registration body for clinical physiologists, covering the respiratory, sleep and cardiac fields, and renal dialysis technicians. Clinical physiologists have applied to be regulated under the HPCA Act.

[22] The SDHB also pays for Ms Glasson's membership to the ASUM, the NZ Society of Cardiopulmonary Technology and the Cardiac Society of Australia and New Zealand.

[23] Ms Glasson's position description requires her to hold an appropriate post-graduate qualification in echocardiography. The DMU is such a qualification, but not the only appropriate one.

[24] Unlike clinical physiology, sonography is regulated under the HPCA Act. Sonographers are required to be registered with and hold an APC from the MRTB.

[25] On 28 September 2012, Ms Glasson also obtained registration with the Medical Radiation Technologists Board (MRTB), with the scope of practice of ultrasound. She did so voluntarily as the SDHB did not require her to be registered with the MRTB. However, her manager, Lisa Wilson, who is a senior cardiac physiologist and the Manager of Diagnostic Testing, supported Ms Glasson's application for registration.

[26] Ms Glasson has maintained her registration with MRTB since 2012. The SDHB does not pay for that registration because it does not require her to be registered with the MRTB.

[27] After these proceedings were commenced, in May 2017, Ms Glasson gained an APC from the MRTB. She now holds current APCs under the CPRB and the MRTB.

[28] Since 1996, one of Ms Glasson's roles has been to train and supervise trainee echocardiographers. She has trained and supervised at least seven of them.

[29] Ms Glasson is currently the clinical supervisor for a trainee studying for her DMU, who is also employed by the SDHB in Invercargill. Like Ms Glasson, this trainee has come up through the clinical physiology pathway.

[30] In order to be an ASUM-approved clinical supervisor Ms Glasson has to be registered with the MRTB in the relevant field of practice, which she is through her own initiative and at her own cost. The ASUM has approved her appointment as clinical supervisor of the current trainee.

[31] SDHB has had difficulty meeting demand for the number of cardiac ultrasounds it needs to undertake in Invercargill. Ms Glasson works .8 of a full time equivalent (FTE) position. For a number of years the SDHB has had to engage her to do extra hours over and above her .8 FTE hours to meet demand. The SDHB has had trouble attracting and retaining enough suitably qualified and experienced cardiac clinical physiologists in Invercargill.

[32] In a typical month, Ms Glasson performs about 120 adult and 10 paediatric cardiac ultrasounds, and undertakes about two stress echo imaging sessions. She performs about 10 electrocardiograms per month[1]. Clinical physiologists commonly perform electrocardiograms.

The history of the MECAs

[33] From about 1 July 2003, Ms Glasson's work was covered under the Professional, Technical and Related Employees Collective Employment Agreement between the PSA and the Southland DHB.

[34] Ms Glasson joined APEX in 2004. From 1 October 2004, her work was covered under the Cardiopulmonary Technologists/Scientists/Technicians National Collective Agreement between APEX and the DHBs.

[35] From 1 September 2007, the first Clinical Physiology National Collective Agreement between APEX and the DHBs came into force. The SDHB says Ms Glasson's work was covered under this agreement. Subsequent versions of this MECA have remained in force, and the SDHB says this is the appropriate MECA for Ms Glasson's work.

[36] In early 2007, the first Medical Radiation Technologists Collective Agreement between APEX and the DHBs came into being. It covered employees who used diagnostic imaging, including ultrasound. It covered sonographers or student/trainee sonographers, and any employee substantially employed as one, even if they may have used a different title. Previously such employees were covered under the Cardiopulmonary Technologists/Scientists/ Technicians MECA.

[37] The first national Clinical Physiologists MECA commenced on 1 September 2007. It did not cover sonographers.

[38] A further Medical Radiation Technologists MECA came into force on 1 October 2009. It continued to include sonographers.

[39] By the time that MECA expired, the parties had entered into negotiations for a separate MECA (with 15 DHBs) that would cover sonographers. That was partly in

[1] These figures are from Ms Glasson's application for her APC from the CPRB signed by Ms Wilson on 22 August 2016.

recognition that there was difficulty in recruiting and retaining sonographers and in the hope that improved pay and conditions would remedy that problem.

[40] Therefore, from 1 October 2011, the medical radiation technologists and the south of Auckland sonographers have had different MECAs. Sonographers are no longer covered under the Medical Radiation Technologists MECA.

[41] In a letter dated 14 August 2013, the SDHB replied to a letter from APEX about transferring Ms Glasson to the Sonographers MECA. It suggested that the negotiation and agreement on the separate sonographers collective agreement in 2011/2012:

> …has created the current ambiguous situation, we believe the matter should be referred back to the upcoming negotiations for clarification (i.e. is this similar role included or excluded in the sonographers coverage clause). We accept that there may also need to be discussions during the upcoming clinical physiologists' negotiations, if a special exclusion is required, though we believe this could be covered off by way of a variation if there is agreement reached during the sonographer negotiations. If you accept this suggestion, are you agreeable to us forwarding the relevant correspondence to the DHB advocate for the sonographer negotiations, so that the issue can be clearly understood by the DHB parties?

[42] However, there was no specific exclusion of Ms Glasson from the Clinical Physiologists MECA or inclusion of her in the Sonographers MECA agreed on during subsequent negotiations for either MECA.

[43] Therefore, so far, Ms Glasson has remained on the Clinical Physiologists MECA.

Issues

[44] The fundamental question is which MECA covers Ms Glasson's work? Is her work only covered by the Clinical Physiologists MECA as the DHB contends or solely within the coverage clause of the Sonographers MECA as she claims?

[45] In order to assess that I have to interpret the coverage clauses and consider Ms Glasson's qualifications, her job title, her work, her work experience and her level of independent practice.

[46] The second issue is whether, without her employer's agreement, Ms Glasson can change the MECA under which she is employed.

[47] If she can, when did she become qualified to be covered by the Sonographers MECA? When she gained registration with the MRTB? When she identified to the SDHB that she should be covered under the Sonographers MECA? When she gained her first APC from the MRTB?

The relevant law

[48] Section 54(3)(a)(i) of the Employment Relations Act 2000 (the Act) provides that coverage clauses are mandatory in collective agreements.

[49] The relevant part of s 56 of the Act provides:

> (1) A collective agreement that is in force binds and is enforceable by —
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> (a) the union and the employer that are the parties to the agreement; and
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> (b) employees —
>
> (i) who are employed by an employer that is a party to the agreement; and
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> (ii) who are or become members of a union that is a party to the agreement; and
>
> (iii) whose work comes within the coverage clause in the agreement.

The parties' positions on coverage

[50] The Sonographers MECA is in force. Ms Glasson contends it is enforceable by her:

- as an employee who is employed by the SDHB,
- which is an employer who is party to the agreement,
- because she is a member of the union that is party to the agreement; and because her work comes within the coverage clause in the agreement.

[51] Mr Manning submits that the question of whether an employee's work is covered by a particular collective agreement is not a matter for either the employer or the union parties to decide, or even to agree upon. It is a matter of the application of s 56 of the Act, to decide whether the employee's work comes within the coverage of a particular collective agreement. That needs to be determined objectively having regard to the work and to the interpretation of the agreement's coverage clause.

[52] He submits that the only coverage clause, and therefore the only MECA, that covers the work Ms Glasson does and has done for many years, is the Sonographers MECA.

[53] In contrast, for the SDHB, Mr Churchman submitted that there is a functional overlap in the coverage of the Physiologists and the Sonographers MECAs. However, Ms Glasson's job is not a sonography job but a clinical physiologist's role, although it contains cardiac sonography. The SDHB says her work falls more clearly into the Physiologists MECA because it reflects her range of duties, which include clinical physiology duties in the cardiac scope of practice, and the SDHB's particular requirements.

[54] The SDHB says Ms Glasson meets the definition of a clinical physiologist in the Physiologists MECA. She is an employee who has a relevant post-graduate qualification, the DMU, or equivalent and meets the minimum standards as set by the appropriate professional body, the CPRB, in the discipline in which she practises, which is clinical physiology.

Analysis of coverage clauses

[55] The same principles of construction apply to interpreting collective agreements as apply to interpreting other contracts.

[56] The Employment Court case of *Aviation and Marine Engineers Association Inc and New Zealand Amalgamated Engineering, printing and Manufacturing Union Inc v Air New Zealand*[2] held that under collective agreements:

> [140] Coverage of work (and therefore the employees who perform that work) … is not determined by job descriptions issued to individual employees covered by those agreements so that, in effect, coverage may be determined, or affected significantly, unilaterally by the employer. A job description of work affected by the coverage clause of a collective agreement must confirm to, and if necessary yield to, the collective agreements coverage clause.
>
> [141] Where an employer has multiple collective agreements affecting the employment of employees (including in the same part of the business), the provisions of a collective agreement governing any particular situation will be determined, first, by which collective agreement (if any) covers the issue. This will be done by considering the coverage of the affected employees by reference to the work performed by them.

Physiologists MECA

[57] The coverage clause in the Clinical Physiologists MECA provides cover to:

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[2] [2013] NZEmpC 172.

> All employees employed as Clinical Physiologists, Clinical Physiology Technicians, ECG Technicians and employees employed as trainees undergoing training as Clinical Physiologists, Clinical Physiology Technicians, ECG Technicians and any employee employed as above who may from time to time use a different title.

[58] A 'clinical physiologist' is defined in clause 2 of the MECA as meaning:

> …an employee who holds a relevant post-graduate qualification or equivalent and meets the minimum standards as set by the appropriate professional body in the discipline in which the employee practises.

[59] The coverage clause is circular because it does not refer to the kind of work being undertaken, but to the names of covered positions despite stating that someone may be employed as a clinical physiologist without always using that title. However, Ms Glasson clearly meets the clause 2 definition, as she has a relevant qualification, meets the CPRB standards and has an APC from the CPRB.

[60] The 10 echocardiograms performed by Ms Glasson each month are the type of work a clinical physiologist with a cardiac scope of practice would typically undertake. Her job title as a "technologist" is one that a clinical physiologist would have, but, under the coverage clause, cannot be determinative of the work she actually performs.

Sonographers MECA

[61] The coverage clause in the Sonographers MECA states:

> This collective agreement shall apply to all employees of the named employer parties who are employed or engaged to be employed in ultrasound imaging as sonographers or student/trainee sonographers, and any employee substantially employed as a sonographer or student/trainee sonographer but who may from time to time use different titles, and any employee who is substantially employed in the use of ultrasound imaging equipment for medical diagnostic, therapeutic and associated purposes other than registered medical practitioners.

[62] Clause 2 of the MECA defines 'sonographer' as meaning:

> …any employee who has been registered and passed an examination that is approved by the Medical Radiation Technologists Board (or equivalent) to practice by the Board.

[63] Ms Glasson meets the definition of sonographer in clause 2. She is an employee who is registered by the MRTB, passed an examination that is approved by the MRTB (the DMU) to practice by the Board, and has an APC issued by the Board.

[64] Ms Glasson's job title does not disentitle her from coverage under the Sonographers MECA – because a sonographer "may from time to time use different titles".

MRTB scopes of practice and prescribed qualifications – how do these apply to Ms Glasson's work?

[65] On 1 August 2013, the year after Ms Glasson obtained her registration with the MRTB; the MRTB published a notice in the New Zealand Gazette about scopes of practice and prescribed qualifications, as it was required to do, under sections 11 and 12 of the HPCA Act. The MRTB divided the medical radiation technology profession into two groups. Mr Manning submitted that sonographers are medical imaging practitioners, as defined by the MRTB, who:

> …use different technologies to create images of the human body for diagnosis and the staging and management of disease.

[66] The MRTB defines the scope of practice of a sonographer:

> Sonographers are responsible for the outcome of the diagnostic ultrasound examination. The outcome of the examination is recorded electronically to allow for consultation with other health and medical practitioners.
> Sonographers perform a wide range of real-time diagnostic examinations and may at their discretion (and in accordance with clinical and workplace guidelines) extend the examination to include relevant regions and/or sequences not suggested in the referral.
> Sonographers' competencies include, but are not limited to, patient care, ultrasound physics and technology, anatomy and physiology identification and assessment, diagnostic interpretations of the ultrasound findings, bioeffects and the use of ultrasound for the examination, and quality assurance.

[67] There is no question that Ms Glasson has the qualifications the MRTB prescribes for registration with it. She has a qualification in ultrasound approved by the MRTB (the DMU) and appropriate sonography experience.

[68] Ms Glasson's work fits the definition of medical imaging practitioners. The MRTB has issued her an APC as a sonographer. Therefore, she can practice within the scope of practice of a sonographer.

[69] The great majority of Ms Glasson's work is sonography work undertaken quite independently although under the guidance of and with the consultation of cardiologists.

Level of supervision

[70] Evidence and submissions for Ms Glasson are to the effect that if she really was a cardiac physiologist the level of supervision she receives is insufficient because, in fact, she acts as independently as a sonographer does. The SDHB disagrees with that. It supports its view by evidence from Lisa Wilson, who is a board member of the CPRB. Ms Wilson is also the manager of Diagnostic Testing at Southland Hospital and Ms Glasson's manager. It is her view, and that of the CPRB who issues Ms Glasson's APCs, that Ms Glasson is appropriately supervised and supported as a clinical physiologist, despite a cardiologist being on the same site only infrequently.

[71] It is useful to examine the history of supervision for Ms Glasson's echocardiology work.

[72] In 1996, the SDHB appointed Ms Glasson to being solely responsible for the cardiac ultrasound service. At that time, there was no cardiologist at either Southland or Dunedin Hospitals. Ms Glasson had no post-graduate echo qualification then and only limited experience in echocardiography. Therefore, the SDHB contracted a former cardiac sonographer to undertake a year-long random audit of Ms Glasson's ultrasound tapes and reports. After that, the auditor confirmed Ms Glasson's competency in undertaking and reporting echo studies.

[73] After 1996 until 2000, at different times, there were either one or two cardiologists with the SDHB based in Dunedin. Ms Glasson self-referred her tapes and draft reports of any echo studies that demonstrated unusual pathology to the cardiologists for their input. She estimates she sent about 5-10% of her studies to them, with 90-95% of her echo reports going directly to the relevant clinicians without any review or oversight.

[74] From 2000 until the end of 2015, Ms Glasson says she was independently performing and reporting almost all of the echocardiograms. She says there was no formal clinical supervision or support within the Southland Hospital for the echo service. However, she sent any adult patient echoes that demonstrated complex or abnormal pathology to either of two cardiologists at Dunedin Hospital for review. She also sent a small number of the more complex paediatric echo studies to a paediatric cardiologist at Starship Hospital.

[75] In January 2016, the SDHB appointed a cardiologist with a specialty in echocardiology, Dr Pemberton. He is based in Dunedin and visits Southland Hospital about twice a month for two days at a time. He spends half a day of each visit on patient consultation. Ms Glasson's evidence is that since Dr Pemberton's appointment:

- She is not supervised when undertaking echo studies unless they are stress echo studies when Dr Pemberton supervises the test. This is only a few studies at most during the three days a month Dr Pemberton is not holding patient consultations.
- 20-30% of adult echoes are referred to Dr Pemberton for his review and sign-off. Ms Glasson issues the rest directly to the referring physician.
- Another cardiologist's patient echoes are sent to him for review. However, some of those echoes may be 6 months old.
- Of the paediatric echo studies any in which Ms Glasson identifies significant pathology (approx. 15% of them), she sends to Starship Hospital to a paediatric cardiologist for review.

[76] Ms Wilson is a qualified clinical physiologist and registered with the CPRB. She also holds and APC from the CPRB. Her scopes of practice are cardiac physiology and respiratory science. When Ms Wilson is absent from the hospital, Ms Glasson is the next senior cardiac physiologist, and can give guidance to physiology team members on issues to do with abnormal test results or contraindications to perform tests such as exercise tolerance tests. Ms Wilson says someone who was purely a sonographer could not give such guidance.

[77] Ms Wilson is not Ms Glasson's "clinical lead" in relation to patient-related issues arising out of the echocardiography service. That is Dr Pemberton. However, Ms Wilson is still the clinical lead for workload issues or problems with referrals.

[78] Ms Wilson and Lynda McCutcheon, the SDHB's Chief Allied Health Scientific and Technical Officer[3], say that Ms Glasson practises with the kind of appropriate supervision the SDHB and the CPRB expects of clinical physiologists

[3] At the time she gave her evidence.

undertaking echocardiography with Ms Glasson's qualifications and level of experience.

[79] Dr Pemberton wrote a letter, which is annexed to Ms Glasson's third brief of evidence, in which he states that all cardiac sonographers and cardiac physiologists should have clinical supervision from a suitably trained cardiologist. He notes that he is the responsible cardiologist for the SDHB and the Southland Hospital. He states there is a departmental agreement on what Ms Glasson should report to him. He also acknowledges that the Cardiac Society of Australia and New Zealand has issued guidance that all cardiac sonographers should have their reports formally read by a cardiologists. However, the SDHB is an exception to that. He wrote:

> The role of a Sonographer or Physiologist is not determined by the level of supervision they receive but is driven by the level of skills they have in their chosen field of cardiology. With regards to Kerren, she has exceptional skills as a sonographer both with adult cardiology, adult congenital cardiology and paediatric scanning. She currently performs at the level of an independent specialist which is above that of a Cardiac Sonographer given the complexity of the work and the lack of full time clinical support. The direct comparison would be with a General Ultrasound Sonographer and in this field, the Sonographers do not provide clinicians with preliminary reports and do not release reports unsupervised as is the case with Cardiac Sonographers in the SDHB.

[80] Ms Wilson was well aware that Ms Glasson applied for registration with the MRTB because she wrote her a letter of commendation. In that letter, written prior to Ms Glasson's request to be treated as a sonographer, Ms Wilson wrote that Ms Glasson conducted adult and paediatric transthoracic ultrasounds and:

> As a qualified cardiac sonographer Kerren competently and independently performs full diagnostic cardiac u/s examinations on both adult and paediatric patients in a timely and safe manner within the Diagnostic Testing Department under the guidance of staff cardiologists and medical physicians within the Southern DHB.
> Kerren, as the senior cardiac sonographer at Southland Hospital is also responsible for supervising, training and guiding trainee cardiac sonographers within the department.

[81] Although Ms Wilson referred to Ms Glasson as the senior cardiac sonographer at Southland Hospital, since 2011 she has been the only cardiac sonographer with a post-graduate qualification.

[82] Ms Wilson had no concerns about calling Ms Glasson a sonographer in her letter to the MRTB.

[83] I accept that Southland Hospital has specific needs because of its relative isolation and the fact that there is no cardiologist on-site. In Ms Glasson, it has a highly trained and highly skilled independent echocardiologist, whose skill and experience is respected by the cardiologists she works with and by the management of the SDHB. I am satisfied that because of her level of skill and experience, and the special constraints of the SDHB, she operates with greater independence than some other clinical physiologists around the country with a cardiac scope of practice.

[84] The SDHB requires Ms Glasson to remain qualified to work as a cardiac physiologist. There is no overarching legal requirement for her to be registered with and have an APC from the CPRB, because the HPCA Act does not apply to clinical physiologists. However, the SDHB is entitled to require that of Ms Glasson as a term of her employment.

[85] From time to time, the SDHB has a need to draw on Ms Glasson's skills as a cardiac physiologist outside of echocardiography. It wishes to continue to do that. However, for the far greater proportion of Ms Glasson's time, she is engaged in echocardiography, or cardiac sonography.

[86] There is no suggestion that Ms Glasson seeks to ignore Southland Hospital's requirement that she remain registered and capable of undertaking the clinical physiology scope of practice she is registered for under the CPRB.

[87] I do not consider that the level of supervision Ms Glasson is under is in and of itself determinative of whether her work is sonography work or clinical physiology work. However, it is relevant to my consideration.

[88] Ms Wilson's evidence reinforces that Ms Klenner, Ms Glasson's manager at the time she committed to studying for an advanced qualification, was concerned at the lack of an onsite cardiologist. She:

> …considered that advanced qualifications were required to reduce the medico-legal risk to the Hospital and the DHB.

[89] However, Ms Wilson went on to say:

> I would point out that it is not only sonographers who are able to obtain these qualifications. Clinical Physiologists are equally as able to sit and pass the exams and often either choose to do so or are encourage by their employer to do so.

> Kerren was encouraged to undertake the QUT[4] or DMU qualification to increase her skill level, however it was not a requirement of her job or an expectation on her. The qualification was seen as beneficial to Kerren in that it recognised the skill levels she currently holds and assisted her personal development as a physiologist.

[90] In addition, Ms Wilson says that all cardiac physiologists who undertake echocardiology are now expected to undertake a suitable qualification, such as the DMU. That proves that the SDHB sees professional worth in a practical sense in its practitioners who undertake echocardiology having the same kind of qualification as an MRTB registered sonographer.

[91] The DHB's objection to Ms Glasson being moved to the Sonographers MECA is not just that it is worried that she will no longer be able to fulfil her role as a clinical physiologist. It is also that during negotiations with APEX for the Sonographers MECA the DHB representatives sought assurances that the coverage of the Medical Radiation Technologists MECA was not being extended by carving out the sonographers into their own MECA.

[92] Their fear, as far as it could be identified after the fact, was that clinical physiologists or other allied health practitioners, such as midwives, who undertake some sonography as part of their role could becoming eligible for coverage under the Sonographers MECA when they never would have had coverage under the Medical Radiation Technologists MECA. That possibility was overcome by the wording in the Sonographers MECA coverage clause ensuring that only practitioners who are "substantially employed in the use of ultrasound imaging" would be covered.

[93] Noelle Bennett, a radiation therapist and the SDHB's Allied Health Director at the time of the first investigation meeting, gave oral evidence in response to my questions to the effect that if someone was originally a clinical physiologist but eventually was as qualified as a cardiac sonographer, despite otherwise having the same advanced qualifications as a sonographer, they must always be a clinical physiologist and could never become a sonographer. She was not clear on why that would be the case. I consider that cannot be correct, because there are examples of employed sonographers around New Zealand who originally trained and worked as clinical physiologists.

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[4] Queensland University of Technology.

[94] The issue does not lie with the Sonographers MECA extending coverage to more employees than the Medical Radiation Technologists MECA covered but with the prior lack of consideration Ms Glasson, APEX and the SDHB gave to the realities of Ms Glasson's qualifications, experience and her actual work. It cannot be the case that a wrongly classified employee must remain that way because no one had previously considered that her work might merit coverage under a different, and more favourable to her, collective agreement.

[95] Ms Glasson's completion of the DMU was due to strong encouragement from her then manager, and was practically encouraged by the SDHB's provision of funding and study time. It has given her some personal gain, in that if she wishes to move to another role she is qualified to be employed as a sonographer, either with the SDHB or with another DHB. However, the DMU and her consequent registration with the MRTB and her APC with the MRTB are not solely for her personal development, as Ms Wilson suggests. The DMU was for her professional development and has given the SDHB comfort and an ability to rely on her professional skill and qualifications to run what is effectively a sole charge echocardiography practice.

[96] Because the SDHB does not currently have a number of qualified echocardiographers, and has not had for the two decades Ms Glasson has been in charge of the echocardiography service, Ms Glasson's field of expertise and her experience has deepened, but not widened. What I mean by that is that she has become extremely well qualified, skilled and experienced in echocardiography but has not been able to develop any equivalent skill and experience in other areas of clinical physiology, including her previous respiratory scope of practice. In fact, even some cardiac physiology testing is not carried out at Southland Hospital. Ms Glasson's experience is a result of the SDHB's needs at Southland Hospital and of Ms Glasson's dedication to her echocardiology role there. I note that if Ms Glasson was to always remain a physiologist her scopes of practice have narrowed while she has been so substantially undertaking echocardiography.

[97] The fact that Ms Glasson is entitled due to her qualifications, experience and skill level to not only be registered with and have an APC from the MRTB, but to be

approved by ASUM as a clinical supervisor for the trainee seeking to obtain her DMU, is of great benefit to the SDHB.

[98] Mr Churchman invited me to apply the Air New Zealand case referred to above[5] as authority for the proposition that an employee cannot pick and choose unilaterally to move between collective agreements. I disagree that this case is factually similar enough to the Air New Zealand case to be able to be applied as an authority. In that case, the employer was seeking to change employees' conditions of employment unilaterally to suit its business operations. There was no suggestion in that case that any employees had been wrongly treated by their union/s and their employer for a time as being covered by one collective agreement when the work they did was covered by another collective agreement in fact.

[99] I have applied the Air New Zealand case approach to examining what work Ms Glasson actually does as opposed to what title the SDHB has given her, and what work it says she does. The work she does is the defining factor for a decision on coverage.

[100] Although Ms Glasson's pathway was from clinical physiology she is now qualified as a sonographer. That does not mean that she is no longer qualified as a clinical physiologist, indeed she has both qualifications and now is registered and able to practice both as a clinical physiologist and as a sonographer. However, the substantial bulk of her work is as a cardiac sonographer.

[101] Objectively speaking, the substantial bulk of the work Ms Glasson is qualified for and performs is work that falls within the coverage clause of the sonographers MECA. She is at the least an "employee who is substantially employed in the use of ultrasound imaging equipment for medical diagnostic … purposes".

[102] I have also considered the case of *Wilson v Dalgety and Co Ltd*,[6] which was referred to by both parties. In that case, the employee was engaged as a clerk, but 2-3% of his work involved dealing with groceries. He applied to be covered under a grocery retail assistant's award, with its more favourable pay, and not the clerical work agreement he had previously been covered by.

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[5] At footnote 2.
[6] [1940] NZLR 323. A decision of the then Supreme Court, which in 1980 became the High Court.

[103] The Court decided that an employee could only be "subject to" one award or agreement at a time. If a worker seemed to be subject to two awards or industrial agreements that conflicted the court would use the doctrine of "substantial employment" to resolve the issue. Three of the four judges decided that the doctrine applied to the case and meant that because the most substantial part of his work was clerical he was covered by the clerical agreement and his case failed.

[104] Although the *Wilson* case is not directly applicable to this matter, it supports my view that the fair approach, given that the substantial majority of Ms Glasson's work is sonography is that she is covered by the Sonographers MECA, and not the Physiologists MECA.

From what date should the SDHB pay Ms Glasson under the Sonographers MECA?

[105] The question remains from what date coverage under the Sonographers MECA should have kicked in.

[106] For Ms Glasson, Mr Manning's submissions suggest that she was and had been practicing as a sonographer in reality even before she gained registration with the MRTB.

[107] The SDHB's submissions are that could not have been possible, in part, because of s 8 of the HPCA Act, which requires that:

> (1) Every health practitioner who practises the profession in respect of which he or she is registered must have a current practising certificate issued by the responsible authority.
>
> (2) No health practitioner may perform a health service that forms part of a scope of practice of the profession in respect of which he or she is registered unless he or she—
>
> (a) is permitted to perform that service by his or her scope of practice; and
>
> (b) performs that service in accordance with any conditions stated in his or her scope of practice.

[108] According to s 8 of the HPCA Act, Ms Glasson was not able to practice legally as a sonographer until she received her APC from the MRTB, and therefore, she could not have been practising as one. The SDHB says that means she could not have been covered by the Sonographers MECA until she had an APC from the MRTB. She only obtained an APC in May 2017. Therefore, the SDHB claims it

should not need to pay her as if she had been under the Sonographers MECA since May 2013.

[109] Ms Glasson's evidence was that although she had obtained her MRTB registration on her own account she did not apply for an APC as a sonographer any earlier because the SDHB did not acknowledge her as a sonographer and would not pay for the APC.

[110] The problem with the SDHB's reasoning is that it wrongly denied Ms Glasson was covered by the Sonographers MECA. Prior to May 2017, when she applied for and obtained her first APC from the MRTB, Ms Glasson was qualified to obtain an APC. It makes sense that an employee would not want to spend her own money to get an APC if her employer would not agree that she was a sonographer and therefore required an APC.

[111] On 29 January 2015, after Ms Glasson and APEX had been in correspondence with the SDHB to move her onto the Sonographers MECA, APEX sent the SDHB a list of its clinical physiologist members, including Ms Glasson.

[112] The SDHB says that means that APEX accepted and communicated its acceptance to the SDHB of Ms Glasson's coverage by the clinical physiologists MECA.

[113] APEX and Ms Glasson say that is not correct. APEX says it was just recognition for the purpose of Ms Glasson's pay that she was considered by the SDHB to be covered by the Physiologists MECA and needed to continue to be paid while the issue of whether she should instead be covered by the Sonographers MECA was resolved.

[114] I do not accept that Ms Glasson is prevented from claiming that she was covered by the Sonographers MECA because for practical purposes APEX asked for her to be paid under the newly settled Physiologists MECA in early 2015. There was no disadvantage to the SDHB in being asked to keep paying Ms Glasson under the Physiologists MECA. I am satisfied the SDHB understood that Ms Glasson did not agree at that time that she was a physiologist and not a sonographer.

[115] Ms Glasson first asked to be moved to the Sonographers MECA on 6 May 2013. The SDHB could have agreed at that point and the only legal consideration would have been Ms Glasson obtaining an APC from the MRTB. I consider that SDHB needs to pay her as if she had been on the Sonographers MECA since the beginning of June 2013, which is a reasonable amount of time to have allowed the SDHB to consider her request and respond to it positively and ensure she applied for an APC from the MRTB.

[116] I direct the parties to mediation to seek to agree on how much the SDHB owes Ms Glasson. The parties should contact the mediation service to arrange mediation. If the parties are unable to agree on the amount owed, Ms Glasson has leave to return to the Authority to have the amount set.

Costs

[117] I reserve costs until the proceedings are finally at an end. The parties should seek to agree on costs as well as what amount of back pay the SDHB owes Ms Glasson. There is leave to return to the Authority if the parties cannot resolve the question of costs.

Christine Hickey
Member of the Employment Relations Authority