Registry's translation, the French text alone being authoritative.

101st Session **Judgment No. 2567**

The Administrative Tribunal,

Considering the complaint filed by Ms S.M. S. against the Food and Agriculture Organization of the United Nations (FAO) on 20 January 2005 and corrected on 20 May, the Organization's reply of 2 September, the complainant's rejoinder of 19 October and the FAO's surrejoinder of 20 December 2005;

Considering Articles II, paragraph 5, and VII of the Statute of the Tribunal;

Having examined the written submissions and decided not to order hearings, for which neither party has applied;

Considering that the facts of the case and the pleadings may be summed up as follows:

A. The complainant, a British national born in 1950, joined the FAO in 1971. At the material time she worked as a Secretary at grade G-5 in the Union of General Service Staff. Her son was enrolled in two of the Organization's medical insurance plans, namely the Basic Medical Insurance Plan (BMIP), which is compulsory for all staff members by virtue of paragraph 343.2.21 of the FAO Administrative Manual, and the Major Medical Benefits Plan (MMBP), an optional plan set out in Manual paragraph 343.2.22*. According to Manual paragraphs 343.3.11 and 343.4.11, these plans provide worldwide insurance for expenses that are "medically necessary, reasonable and customary for the treatment of sickness, accident or maternity". Manual paragraph 343.4.61(l) provides that the BMIP coverage shall not extend to "charges in excess of reasonable and customary expenses in the locality where treatment is provided", and that "[f]or 'bona fide' emergencies, reasonable and customary limitations may not apply".

The complainant's son underwent an operation on his jaw in December 2001 for which the medical expenses were not fully reimbursed. The insurance brokers Van Breda (hereinafter the "Claims Processor") informed the complainant on 27 May 2002 that the partial reimbursement she had received corresponded to the "reasonable and customary expenses" for that type of treatment. Furthermore, since the surgery undergone could not be considered as an emergency intervention because it was not for an acute life threatening problem, there could be no supplementary reimbursement.

On 18 June 2002 the complainant informed the Human Resources Policy, Planning and Systems Service that she disagreed with the Claims Processor's decision of 27 May and its definition of "emergency",and that she wished to initiate the procedure for settling disputes over medical matters provided for in Manual Section 343. On 31 July she sent an e-mail to the Claims Processor, informing the latter that she had decided to initiate the aforementioned procedure. In an e-mail of 30 August 2002 the Claims Processor provided her with the names of three independent medical arbitrators amongst whom her designated doctor was to elect one. The Claims Processor's e-mail remained unanswered.

On 7 July 2003 the complainant lodged an appeal with the Director-General, requesting that the Organization intervene on her behalf with the Claims Processor "to have the bona fide emergency of [her] son recognized and the correct reimbursement made"; alternatively she asked that the Organization pay the amount not reimbursed by the Claims Processor. The Assistant Director-General in charge of the Administration and Finance Department dismissed the appeal on 21 August as irreceivable for lack of jurisdiction. On 19 September 2003 the complainant filed an appeal with the Appeals Committee contending that the surgery undergone by her son was a bona fide emergency warranting waiver of the application of "the reasonable and customary limits" rule.

In its report of 18 May 2004 the Appeals Committee observed that the expression "medical emergency" had been clearly defined and its meaning agreed upon on a contractual basis between the Organization and the Claims Processor. It considered that, in the light of that definition, there were no grounds for the Claims Processor to restrict the term "emergency" to an "acute life threatening intervention". It concluded that since the participants in the medical insurance plan are bound by any interpretation of the insurance contract agreed to by the FAO and the

insurer, the Organization had “omitted to discharge its obligation with regard to the implementation of the Plan with all due care”. The Committee therefore recommended, firstly, that the Organization ask the Claims Processor to reconsider the complainant’s claim in the light of the contractual definition of medical emergencyand, secondly, that it remove from the medical insurance plan “any ambiguity regarding the term ‘bona fide emergency’”, taking measures if necessary to amend Manual Section 343.

By a letter of 15 October 2004, which is the impugned decision, the Director-General informed the complainant that, although in the Organization’s view the Appeals Committee had no jurisdiction to deal with her case, he accepted the Committee’s first recommendation. Noting that according to Appendix A of the insurance contract a “medical emergency” is an accidental injury or sudden and unexpected onset of a condition requiring immediate medical or surgical care, he added that the expressions “bona fide emergency” and “medical emergency” were considered to be conceptually the same. He also emphasised that, whilst the Organization would ask the Claims Processor to reconsider her claim, if no agreement could be reached with the Claims Processor, the matter would have to be resolved in accordance with the specific procedure provided for the settlement of medical disputes. He rejected the Committee’s second recommendation on the grounds that the expression “bona fide emergency” was not ambiguous, but a medical expression which “should be given its meaning on a case-by-case basis and, in the case of [a] dispute, be referred to medical experts”.

Further to that decision, on 29 November 2004 the Organization sent an e-mail to the Claims Processor asking it to reconsider its position on the complainant’s case. On 15 December 2004 the Claims Processor indicated that the case had been resubmitted to its medical adviser, who had confirmed that the surgery undergone by the complainant’s son could not be considered as a consequence of a medical emergency. It further explained to the complainant how to proceed if she wished to initiate the procedure for settling disputes over medical matters.

B. The complainant contends that the definition of the term “emergency” for the purposes of reimbursement of medical expenses is not a purely medical matter to be decided on a case-by-case basis by a medical board. She consequently contests the Organization’s view that, should she fail to reach an agreement with the Claims Processor, the matter must be resolved in accordance with the specific procedure established for the settlement of medical disputes, i.e. the arbitration procedure set out in Manual Section 343.

She submits that the Claims Processor, by imposing its own definition of “emergency” as a life threatening situation, breaches Manual paragraph 343.4.861, according to which “[p]articipants in the [medical insurance] Plan are bound by any interpretation of the insurance contract agreed to by the Organization and the insurer”. She points out that the term “life threatening situation” is not mentioned in the contract or in the Manual. Other persons have likewise experienced difficulties in understanding what is meant by an “emergency” and the issue has been raised in the Joint Advisory Committee on Medical Coverage for a recommendation on the definition to be used. Although that Committee has not yet reached an agreed definition of “bona fide emergency”, she asserts that there is “a fair degree of agreement” amongst its members that narrowing the meaning to an immediate life-threatening situation is “too restrictive and was not the intention when the term emergency was included in the contract”.

Regarding the reference made by the Appeals Committee to the definition of a medical emergency in Appendix A of the insurance contract, the complainant indicates that that appendix was not supplied to her before she filed the appeal. She adds that the definition in question does not appear in the Manual. In addition, she submits that she suffered stress and anxiety due to “the difficulties experienced in trying to achieve a just resolution [of her] case”.

The complainant requests that her medical expense claim be exempted from the “reasonable and customary” limitations. She claims payment of the “additional reimbursement” due to her, together with “interest on the monies withheld from [her] since December 2002”. She also asks the Tribunal to award her 10,000 United States dollars in moral damages for the stress and anxiety suffered.

C. In its reply the FAO contends that the complaint is irreceivable, as the complainant is asking the Tribunal to take a decision on the definition of the expression “bona fide emergency”, which is a medical concept. Manual Section 343 establishes that the specific procedure for settling disputes over medical questions is to refer the matter to a medical arbitrator. It is a general principle of law that a special provision establishing a “specific recourse” prevails over a general provision. Referring to the case law, it submits that the matter should be resolved in another forum since neither the members of the Appeals Committee nor those of the Tribunal have “the specific competence needed to advise on medical questions”.

The Organization draws attention to the fact that the complainant initiated the dispute settlement procedure for medical matters with the Claims Processor in July 2002, but then decided to lodge an appeal with the Appeals Committee instead. It argues that the absence of a definition of the expression “bona fide emergency” provides more flexibility to the staff, because the medical arbitration procedure permits a medical interpretation on a case-by-case basis.

In addition the Organization submits that the complainant has produced no evidence to support her allegation that her case was not handled with due care. It takes the view that, on the contrary, it has been “extremely supportive to the complainant’s case” and points out that it has offered to pay half the fees payable to the medical arbitrator.

D. In her rejoinder the complainant presses her pleas. She maintains that the concept of a bona fide emergency is not a medical one, and argues that resolving medical cases on a case-by-case basis would result in unequal treatment.

E. In its surrejoinder the Organization maintains its position.

CONSIDERATIONS

1. On 28 December 2001 the complainant’s son, who was enrolled in two of the medical insurance plans provided for in Section 343 of the FAO Manual, underwent an operation in Rome to treat an inflammation of the jaw. The Claims Processor agreed to reimburse only about half the cost of the operation on the grounds that the case could not be considered as an emergency intervention. According to the Claims Processor commenting in an e-mail of 27 May 2002, the concept of an emergency intervention applied only in the case of an acute life-threatening problem.

2. The complainant contested that decision and in the last resort brought the dispute before the FAO’s Appeals Committee. In its report of 18 May 2004 the latter recommended inter alia that the Organization ask the Claims Processor to reconsider the complainant’s claim for reimbursement in the light of the definition of medical emergency given in the insurance contract. Appendix A of the contract contains the following definition:

“Medical emergency

An accidental injury or sudden and unexpected onset of a condition requiring immediate medical or surgical care.”

The Appeals Committee also recalled the Tribunal’s case law, according to which “[i]n the absence of any information enabling the exact meaning of [an] expression to be established, the Tribunal must keep to a literal interpretation of the terms used in the contract. Since the clauses are intended for the use of the insured, it is a question of ascertaining how the latter should understand the terms” (see Judgment 2290, under 4). It emphasised that in the present case there were no grounds for the Claims Processor to restrict the scope of the term “emergency”.

On 15 October 2004 the Director-General of the FAO accepted that recommendation, while pointing out that the Appeals Committee had no jurisdiction over the case and drawing attention to the fact that in his view the terms “medical emergency” and “bona fide emergency”, in the meaning of Manual paragraph 343.4.61, were conceptually the same. That paragraph is worded as follows:

“Coverage shall not extend to:

[...]

(l) charges in excess of reasonable and customary expenses in the locality where treatment is provided. For “bona fide” emergencies, reasonable and customary limitations may not apply;

The upper limit reasonable and customary charge for surgical procedures will be the 90th percentile [...].”

The Director-General noted that, should the Claims Processor and the complainant fail to reach an agreement, the matter should be resolved in accordance with the arbitration procedure foreseen under Manual Section 343.

Having been asked to reconsider its decision, the Claims Processor resubmitted the case to its medical adviser. On 15 December 2004 it confirmed its initial decision, pointing out that the two expressions “bona fide emergency” and “medical emergency” were conceptually the same. The Claims Processor reminded the complainant that she was entitled to challenge the decision by resorting to the arbitration procedure.

According to the Manual’s provisions concerning the reimbursement procedure, participants in the medical insurance plan are bound by any interpretation of the insurance contract agreed to by the Organization and the insurer. They also stipulate that any disputes shall be settled in the manner specifically provided for in the contract, which reads as follows:

“Disputes between an insured person and the Claims Processor/Team Leader shall be limited to medical questions. Such disputes, unless settled by negotiation, shall be referred to a medical arbitrator designated jointly by a doctor chosen by the insured person and by the Claims Processor/Team Leader’s doctor. [...] The decision of such medical arbitrator shall be final. [...]”

3. The complainant challenges the decision taken by the Director-General on 15 October 2004.

4. The FAO contends that the complaint is irreceivable on the grounds that the Tribunal is not competent to deal with a dispute concerning a purely medical matter.

This argument reflects a confusion between the Tribunal’s competence, *stricto sensu*, to deal with the subject of a dispute and the limitations it must place on its power of review in certain areas. In the case of medical disputes, the Tribunal may not replace the findings of medical boards with its own. But it does have full competence to say whether there was due process and whether the reports used as a basis for administrative decisions show any material mistake or inconsistency, or overlook some essential fact, or plainly misread the evidence (see Judgment 2361, under 9).

The defendant’s argument on this point is all the more unfounded for the fact that the matter raised by the complainant is a legal and not a medical one. Determining what general meaning should be attached to the terms “bona fide emergency” (Manual paragraph 343.4.61(l)) and “medical emergency” (Appendix A of the insurance contract) is clearly a legal question with regard to which the Tribunal in principle need not restrict its power of review. On the other hand, the issue of whether a particular concept is applicable to a specific case in the light of the medical problems involved is a purely medical matter.

5. As far as the legal analysis of the situation is concerned, the Tribunal notes that the concept of bona fide or medical emergency, in the meaning of the Manual and the insurance contract respectively, is an indeterminate legal notion which leaves the administrative authority considerable discretion in its application. But that does not allow that authority to restrict the general meaning of the concept beyond what may reasonably be inferred from the relevant texts. In this case, the restriction of a bona fide or medical emergency solely to cases where the life of the insured person is threatened or his vital bodily functions are affected is supported neither by the wording of Appendix A of the insurance contract nor by that of Manual paragraph 343.4.61(l), to which the defendant Organization and the Claims Processor both attribute the same restrictive meaning.

It may be recalled that where a doubt arises regarding the meaning which should reasonably be given to the clause of a contract, according to the principle of good faith the clause should be interpreted to the detriment of the party which drafted the contract.

Moreover, the meaning of bona fide or medical emergency cannot be simplistically limited to cases where, if the medical intervention in question does not take place, the patient will die or lose one of his vital bodily functions. Such a simplistically restrictive interpretation is particularly inadmissible insofar as the physician who performed the operation whose reimbursement is in dispute had himself determined that there was a medical emergency.

6. As far as the procedure is concerned, it must be recalled that according to Article VII, paragraph 1, of the Statute of the Tribunal “[a] complaint shall not be receivable unless the decision impugned is a final decision and the person concerned has exhausted such other means of resisting it as are open to him under the applicable Staff Regulations”. The Tribunal will on its own motion examine whether this condition of receivability is met (see Judgments 60, 1082 and 1095).

In the present case, neither the impugned decision taken by the Director-General on the basis of one of the

recommendations of the Appeals Committee nor the decision of the Claims Processor constituted a final decision on the complainant's claim. According to Manual Section 343, disputes between the insured persons and the Claims Processor may be referred to a medical arbitrator designated jointly by a doctor chosen by the insured person and by the Claims Processor's doctor. In its decision of 15 December 2004 the Claims Processor reminded the complainant that she could avail herself of that possibility and made proposals for suitable arrangements.

The issue of whether the operation undergone by the complainant's son was in fact an emergency intervention may be resolved by resorting to the arbitration procedure. The outcome may or may not be favourable to the complainant, regardless of the dispute which has arisen between the parties concerning the general definition of the concept of a medical emergency.

In view of the above, the Tribunal must conclude that this complaint is irreceivable because the complainant has not exhausted all means of resisting it as stipulated in Article VII, paragraph 1, of the Statute of the Tribunal.

DECISION

For the above reasons,

The complaint is dismissed.

In witness of this judgment, adopted on 17 May 2006, Mr Michel Gentot, President of the Tribunal, Mr Seydou Ba, Judge, and Mr Claude Rouiller, Judge, sign below, as do I, Catherine Comtet, Registrar.

Delivered in public in Geneva on 12 July 2006.

Michel Gentot

Seydou Ba

Claude Rouiller

Catherine Comtet

---

* According to Manual paragraph 343.2.22, the MMBP provides "partial reimbursement for physician fees (not covered by the BMIP), and for prescription drugs and medicine".

Updated by PFR. Approved by CC. Last update: 21 July 2006.