NZRDA President's Report 2018

Auckland 30th March 2019

Welcome everyone to the New Zealand Resident Doctors Association Annual General Meeting for the 2018 year.

And what a year it has been. I was elected president this time last year, taking over the reins from Dr Sara Moeke. I had been a member of the RDA for three years, was on bargaining team for the 2016/2017 "Safer Hours" campaign, and had held the positions of Wellington Representative, then Vice President. During that time, we settled a MECA, and cemented in our contract hard fought for "safer hours" provisions. Revolutionary "Safer Rosters" were being implemented across the country, and the DHBs assured us they were "actively recruiting" the additional staff required. We had participated in a remuneration review (I know this didn't result in any meaningful change – but hey, at least the DHBs had turned up this time). In additional to this, we were tackling bullying and harassment head-on, and were also working on improving the trainee intern to house officer transition.

This time last year, we had already initiated for another round of bargaining, and we had what (at the time) felt a semi-functional relationship with our DHB colleagues. We had a passionate and knowledgeable national executive, and ongoing support from the dedicated CNS team. We were strong and united.

When I took on the role I naively thought – how hard could it be?

Oh how wrong I was.

This year has been challenging, for me personally, and for us as a collective. The bargaining process has been immensely frustrating (at times infuriating), unnecessarily drawn out, acrimonious and confrontational. The formation of STONZ has added complexity. As a result of their formation, subsequent bargaining and MECA settlement, we find ourselves in a new

and precarious position – very different to the position I would have imagined us being in only twelve months ago.

We initiated for this round of bargaining on December 31st 2017. Our list of claims had been decided by you – the RMOs. We brainstormed ideas at our end of year delegates meeting in late 2017. A list of potential claims was then sent out to all members for consultation, consideration and feedback. Increased pay and improved teaching and training provisions were a common theme. These things are obviously important to us as RMOs. Our bargaining team was then established – a diverse group of willing individuals from across the country, varying in experience and specialty.

We first met with the employers on the 6th and 7th of March. At this time, we tabled a number of claims – a pay increase, additional steps on the salary scale, increased medical education leave, an increase to the on call allowance, increased protected teaching time, to name only a few. And, in my opinion most importantly, included on this list was a claim to move schedule 10 in the body of the collective, so that it would apply to ALL non-shift rosters across the country.

The DHB's bargaining team did not table any claims. Instead, we were presented with a list of "issues". Included on this list was broad "big picture" stuff. "Delivery of training", "remuneration", "the two-thirds agreement" and of course "Schedule 10". Despite our repeated questioning – their "issues" were vague and lacked specific detail. The employers assured us they did not want to get rid of schedule 10, yet they appeared unable to clearly articulate or communicate to us what their specific "issues" were, and how they wanted to change our contract in order to rectify these.

Bargaining was then delayed or rescheduled on a number of occasions at the request of the DHB team, in part due to the nurses' negotiations and subsequent MECA settlement. We went on to meet a few more times, but it soon became clear, little progress was being made. In order to try and reach a settlement, we proposed a "quick and dirty" deal. This consisted of a fourteen-month term, a two percent plus two percent pay rise, removal of schedule 10 deductions, a compromise with regards to mid-week rostered days off, and an agreement to

have all schedule 10 rosters implemented by December 2018. This offer was rejected by the DHB team, and they made no counter offer. They wanted us to address their schedule 10 “issues” – yet proposed no solutions.

We knew there would be unintended consequences of Schedule 10 – the RDA has never denied this. However, following the horrifying results of the 2016 fatigue survey, inaction on such an important issue could no longer be justified. The risks of continuing to work unsafely, far outweighed the potential for harm as a result of Schedule 10. The issues raised by the DHBs – increased SMO workload and clinical responsibility, continuity of care, increased handover, service delivery demands, dilution of training, retention and recruitment of RMO staff – these are not new issues. And schedule 10 is by no means the cause. Our population is ageing, and our health system is stretched. Schedule 10 has highlighted those systemic issues that have plagued our health service for years – a system which is now, almost at breaking point.

We agreed we needed to find a way forward. A number of options were discussed, and a national meeting or “Hui” was proposed. The function being to review, and establish a plan to address, any and all unintended consequences of schedule 10. At the table would be those parties who could actually bring about change – us, the DHBs, ASMS, the colleges. We wanted to settled our contract, and for this meeting to occur outside of bargaining. The DHBs had other ideas. They wanted us to put bargaining on “hold” until this meeting had been held, the outcome of which would or could affect our negotiations. In retrospect, another clear delaying tactic, and an attempt to get other parties involved. Our proposal, bringing the affected parties together after the contract had been settled “did not meet their needs”.

We subsequently pursued, and have established, a memorandum of understanding (MOU) with ASMS, which outlines an agreed process to resolve unintended consequences arising as a result of the implementation of schedule 10. The DHBs were invited to participate – they declined.

Despite this, we continued to bargain. Remuneration (clause 8.1.2) appeared to be the other major issue. The DHBs tabled two alternative remuneration models, both of which would

have resulted in a pay cut for some of our members. Early on in bargaining, the DHBs had told us they were willing to "invest" in a new remuneration model, it became pretty clear pretty quickly, this was nothing more than talk.

After months of "talking" with no resolution in sight, we demanded the DHBs table claims. How could we reach a settlement, when we did not know exactly what the DHBs wanted?

And boy, did they deliver. In September 2018, almost nine months after we had initiated bargaining, the DHB's finally tabled their list of claims. Along with changes to schedule 10 and our remuneration model, the document contained a plethora of new claims, not previously talked about (or even mentioned) at the bargaining table in the preceding nine months. It was clear – the DHBs wanted more control. Most significantly, they wanted to eliminate (or at least reduce considerably) the role of the NZRDA, and in turn, our ability to advocate for and protect our members. They also wanted to dramatically change the way in which decisions were made, in particular the run review process and changes to run descriptions (the two thirds agreement). In the background, STONZ had formed a union, and were bargaining with the DHBs. I have no doubt this played a significant part in the DHBs assuming the position they did, and the delaying tactics that had preceded this.

We went to mediation; however little progress was made. We issued our first strike notice on the 31st of December 2018, and we went on strike for the first time on the 15th of January 2019. The second, third and fourth strikes followed. There were TV advertisements and there were pickets across the country, all of which attracted significant media attention.

Mediation continued, however the DHBs position has significantly change. Despite all of this, they still want to remove the right the RDA has to agree or disagree to specific changes. In particular, rotation to another hospital or DHB, changes to the provision of training and education, the introduction of shift rosters, rostering of combined periods of on duty and on call in excess of 16 hours, and schedule 10. They also want to weaken those rights we as RMOs have, at a local level, to agree to changes to the way in which we work.

The DHBs resolve seems insurmountable, so with the permission of you the members, we tabled a compromise. An independent third party facilitation process. We would give up our right to agree to change, and hand this over to an independent facilitator, whom would make a recommendation. The DHB CEO could then make the final decision – adopt the facilitator's recommendation, or continue with the status quo.

Despite the DHBs bargaining team (essentially) recommending our proposal, it was rejected in its entirety by the DHB CEOs. They want the final say – pure and simple. To add insult to injury, they now also want to subject the two thirds agreement (or one third disagreement) provision to a facilitation process, and ultimately CEO approval.

The formation of STONZ and their subsequent bargaining and MECA settlement, has added complexity. We are bargaining in an environment we have never bargained in before, and the DHB's have most definitely used this to their advantage. They have settled a far inferior contract with STONZ (albeit with a small financial incentive for some), with a loss of those terms and conditions our predecessors fought so hard to for. The DHBs have used STONZ to try and get rid of all of those protections in our contract they do not like. I do not think that this was STONZ's intention, and I do not think they knew what affect their actions would have on our bargaining. But – it is now obvious. They DHB's have used their contract, which benefits the few (in particular senior surgical registrars) at the expense of the majority (house officers and basic/non-trainees), to undermine our negotiations. Those on the STONZ contract are not our enemies. They are our colleagues, whom we work alongside every day. However, the organisation itself, can no longer plead ignorance. Their actions have negatively affected us, and the way in which we work. Where to from here – I guess time will tell.

We are not alone thought. One good thing that has come out of this round of bargaining is renewed and improved relationships with our union colleagues. We have received overwhelming support from the union movement as a whole, and we are incredibly grateful for this. The STONZ contract is not only a threat to us, but to the union movement in its entirety. So much so, that the Council of Trade Unions (CTU) voted (nine to four) to adopt a resolution that *"expressed concern in the strongest possible terms … for the collective bargaining strategy adopted (by the DHBs) in their MECA negotiations with the RDA"* with

specific reference to *"the undermining of a union that is in bargaining with the potential effect of "union busting" and taking advantage of the vulnerability of resident doctors due to their dependence on changing DHB employment for training".* The resolution also urged the government to *"urgently require the DHBs to discontinue this strategy forthwith".*

Interestingly, our membership has not suffered as a result of the formation of STONZ. It has remained stable throughout 2018, with a number of new members signing up prior to the commencement of strike action, not dissimilar to the 2016/2017 negotiations.

Unfortunately, as a result of this years' tumultuous negotiations, those other issues that are important to us as an organisation – RMO health and wellbeing, bullying and sexual harassment, the trainee intern to house officer transition, part time and flexible working options – have taken somewhat of a backseat. That does not mean we have not made progress, however.

Following on from the work we have done, and are still doing, with regards to bullying and inappropriate behaviour, we conducted a sexual harassment survey mid-last year. There were 503 respondents, 65% female and 35% male. Of those whom responded, 85 individuals reported having had experienced sexual harassment in the last year, and 56 respondents reported witnessing sexual harassment. The main perpetrators were patients (75 cases) and SMOs (52 cases). Alarmingly, only a third of respondents had reported or raised a concern with their employer, and only 40% of those RMOs were satisfied with how the complaint was handled. 87 respondents purposely chose not to raise a concern due to fear of career retribution and/or other negative consequences. It is clear, more work needs to be done in this area. There does not appear to be safe or robust reporting and or management processes in place. Fear of career retribution is an ongoing and complex problem – hopefully our work in other areas (e.g. removal of confidential references) will help in addressing this fear, perceived or otherwise. Patients as offenders is an altogether different issues. The majority of incidences occur on our emergency departments, and I think a coordinated approach is required. A plan to discuss this with our nursing colleagues.

On a more positive note, we have had some “wins” this year. In May 2018 we settled the RNZCGP GPEP collective. Included in this was a salary increase, increased reimbursements, college discretionary leave was changed to study leave, and changes were made to parental leave provisions to make them more equitable. Even with a longer term (eighteen months) bargaining is due to commence again soon. We continue to build on our relationship with the college, and we have attended a number of engagement meetings. We continue to provide advice and support to those registrars moving into private practice employment in their GPEP 2 year.

The RDA’s first Health and Wellbeing Conference was held at the SKYCITY Auckland Convention Centre on the 8th and 9th of November. Unfortunately, I was not able to attend, but by all accounts, it was an overwhelming success. With regards to maintaining and or improving our mental health, a number of practical ideas were identified or suggested by attendees at the conference. It is my hope that, over the coming year, we can further develop these ideas and assist with implementation.

Our work on the trainee intern to house officer transition continues. A provisional HOTTI (House Officer Teaching Trainee Intern) course manual was sent out late last year. The course manual has been subsequently review by senior medical staff at Capital and Coast DHB, and some minor amendments have been made. The final version should be published in the coming months. A focus for this coming year will be the standardisation of house officer orientation across the country, as well as ongoing advocacy for and support of “buddying” for new first year house officers. The other important transition points – house officer to registrar and registrar to SMO – are yet to make their way onto our work plan, but my hope is that this is not too far away.

So – where to from here?

We have another big year ahead of us. With regards to bargaining, we are due to attend mediation again next week, and we have applied for facilitation. We will continue to put pressure on those higher up, in particular the Minister of Health. We have a mandate to strike

for four days, and strike notices have been issued across the country with the exception of Christchurch, a city still recovering from the atrocities of earlier this month.

I am confident we WILL settle this MECA – what the MECA will look like however, well, that is up to all of us. The decisions we make and the actions we take over the coming weeks to months will determine what our contract will look like going forward. Those protections in our contract that are under attack are the protections that make us strong and give us a voice, so that we as RMO's can have our say, and prevent detrimental change from being imposed upon us, and in turn our patients. The DHBs appear determined, they want our "right of veto" gone (or more accurately our right to agree or disagree to changes that affect US). We need to be prepared. We need to be able to recognise and identify change proposals, empower each other to raise concerns, and to stand up and act for the good of ourselves, our patients and our colleagues.

Our role as the NZRDA, is to advocate for and protect our members, and in turn our patients. In todays' health environment, where the pressures and demands on us as doctors are forever increasing, we the RDA are there to act as a buffer, to ensure that the rights, interests, training and health and wellbeing of RMOs are never seen as "less than" service delivery demands.

The hope is that when we settle, we will settle for a longer term. I think both us and the DHBs would like a period of "stability" between negotiations. Our relationship with the DHBs is fraught, but I do hope that we can begin to rebuild following settlement. Despite this, our relationship with those other major players in health – the New Zealand Medical Council, the Council of Medical Colleges, ASMS, NZMSA – remains strong. We will continue to ensure that the RMO voice is heard at every table, in every forum, and at every major discussion in health.

Within the RDA - change is coming.

Our National Secretary, Deborah Powell, will be stepping down at the end of her current term in March 2020. Now is the time to look forward - to review the associations rules, our structure, and the way in which we function. As an organisation, are we still fit for purpose, and what can we do going forward, to provide the best possible service to our members?

To finish off, I would like to take this opportunity to thank my fellow National Executive members for your unwavering support and dedication over the last twelve months. In particular, thank you Kat. On a number of occasions, you have stepped into my shoes and taken charge at very short notice.

To the bargaining team – when we volunteered ourselves for this task, I don't think any of us could have imagined just how protracted and frustrating bargaining would be. We have spent an immense amount of time together, often at the expense of training opportunities, annual leave, and time with family and friends. We do not always agree, but we respect each other's opinions, and I think that is what has made us so effective. Trust me, the situation we are in right now could have been much worse, had we not had these individuals at the bargaining table.

To Deborah and the CNS team. We could not do what we do without you. We keep you busy, oh so busy. Your support and guidance is so appreciated.

And finally to all of you, the delegates – thank you for your dedication and ongoing support. It has not been an easy year. We have relied on you to communicate with members, and to feedback to us during what has been a pretty tumultuous time. I hope you have all enjoyed delegates training – a chance to meet other members, to learn, to relax and enjoy yourselves, and to "re-energise".

Safe journey home, and I look forward to working with you all over the coming year.

Ki te Kotahi te kakaho ka whati. Ki te kapuia e kore e whati.
Alone we can be broken. Standing together, we are invincible.

Dr Courtney Brown
National President
New Zealand Resident's Doctors Association