Resident Doctor

June 2020

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Get in touch

Unit E, Building 3
195 Main Highway, Ellerslie,
Auckland 1051

PO Box 11369, Ellerslie, Auckland 1542

P: 09 526 0280

www.nzrda.org.nz

ask@nzrda.org.nz

facebook.com/nzresidentdoctor

Past President Perspective

Money - It Matters

I know that talking about this might make some of your uncomfortable, but I think we need to start having a conversation about money.

As a profession, we don't like to talk about money. Sometimes I think we consider ourselves "above all of that". In our own eyes, and in the eyes of those that we care for, we are dutiful public servants, dedicated to our work and our patients, and to the advancement of the medical profession.

But actions speak louder than words. Money does matter (to most of us at least). Whether it be picking up additional duties, requesting a relief run, taking some time off to locum, moving to Australia or switching to STONZ, money plays a part in what decision we make career wise. We might not say it out loud, but the message is clear.

I am going to stand up and say that I think we are worth more. We deserve more. We work horrendously long hours, we make complex, time critical and life changing decision on a daily basis, and we care for patients and their families during what is often the worst time of their lives. Our salary does not reflect the work that we do or the hours that we work.

And the demands on us are exponentially increasing. We are seeing more and more patients, and we are doing more for them. Our patients are getting older and more complex and their expectations are higher. If the New Zealand public health system continues to demand more from us, then this work needs be recognised, and we need to be remunerated appropriately.

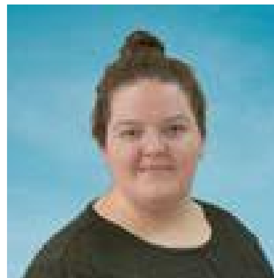
Most of us leave university after six-plus years with a student loan of more than $100,000. As per a recent RDA analysis of the starting salaries of new medical graduates, a first year house officer working a 40-hour week in an urban DHB gets paid $28.12 an hour. Compare this to a newly graduated nurse (with a three-year degree) who gets paid $25.90 an hour, and a new radiation therapist (with three-year degree) who gets paid $27.50 an hour. A new MRI and nuclear medicine technician (> three year qualification) gets paid $31.30 an hour, and a newly graduated psychologist (> three year qualification) gets paid $34.80 an hour. The numbers just don't add up.

There have been (and there always will be) trade-offs in a public health system – budgets are finite, resources are limited, and there is only so much to go around. But there is a tipping point. We cannot care for our patients if we are burnt out, over worked and underpaid. In order to best serve the public and our patients, our health and wellbeing must come first - and money is a part of that. We need to stand up for ourselves because no one else will. For the work that we do to be recognised, we need to ask for it – to demand it even.

How do we go about doing that? Our current contract expires in March 2021, so the bargaining process will begin all over again at the end of this year. I know it might not feel like it sometimes – but as a collective we are powerful. The job that we do and the service that we provide cannot be done by anyone else. Our societal value is immense. In 2021 I challenge you to value yourself enough to stand up and say we deserve more.

Dr Courtney Brown

Former NZRDA President



Let's Talk About Leave

A Guide to Parental Leave & Alternative Holidays

A topic we receive frequent questions about from members of the RDA is leave, specifically, about parental leave and alternative holidays. To help you get your correct entitlement to leave, we have summarised these provisions as follows:-

Parental leave

Parental leave is one of the more complicated areas of the MECA so we do strongly recommend you take a look at the parental leave FAQs on the RDA website (Resource Hub - MECA - MECA FAQs - Parental Leave), if you are still confused get in touch with either the office or your local delegate.

Here are a few tips to help clarify this section of the MECA:-

1. Parental leave is technically leave without pay in that you do not continue to receive your salary whilst on parental leave, but there are provisions that entitle you to remuneration if you are taking parental leave (which we will go into more detail about below). This does sound like a contradiction but it does help understand the difference between the leave entitlement and the payment entitlement.

2. Parental leave and paternity (or partners) leave are two different things so make sure when you submit your paperwork that you are requesting the right leave. If you are wanting to utilise your entitlements from the MECA then you are applying for and taking **parental** leave.

3. If you have been employed by any DHB or any combination of DHBs for at least a year then you are entitled to 52 weeks of parental leave.

4. If you have been employed by DHBs for less than one year you are entitled to 6 months of parental leave. So yes, if you have worked for one day as a RMO you are entitled to 6 months parental leave.

5. If you have taken a break in employment in the 12 months prior to taking parental leave get in touch with us so we can go over the ramifications of this break.

Case Study: Opthalmology Registrar Denied Parental Leave Top Up Payments

NZRDA recently represented an opthalmology registrar who was denied their parental leave top-up payments by a DHB.

The facts in the case were relatively complex. The registrar was due to be working away from their base DHB when they were set to begin parental leave, but the college's training co-ordinator requested the registrar to rotate back to their base DHB to allow another trainee to take up the training position at the other DHB.

On the advice of Human Resources, the base DHB then refused to employ the registrar because they did not want to have to pay the parental leave top-up payment. HR even wrote this in their email to the registrar, a clear breach of the Human Rights Act 1993's prohibition on discrimination against pregnant employees.

Once we became involved the base DHB did employ the registrar but still denied any obligation to pay the parental leave top-up payment. The DHB's chief executive officer also wrote to us to suggest there was no continuing employment relationship between the registrar and the DHB even though the registrar was due to rotate back to the DHB at the conclusion of parental leave. This would have meant the DHB had no obligation to pay costs of training, or costs of employment such as MCNZ, College and indemnity costs during parental leave.

After NZRDA filed proceeding for unjustified dismissal and for breach of the MECA in the Employment Relations Authority the case ended in a settlement.

The case highlights a couple of important points for RMOs to be aware of. First, when negotiating run allocations with training co-ordinators, remember to get advice if you are unsure of what is being offered and what the implications are, and to ensure any changes in run allocation are agreed in writing rather than verbally. Second, if a DHB is attempting to rely on you taking parental leave to reduce or remove any entitlement, it probably is unlawful.

6. You can take parental leave at any time during the first year of the child's life, some RMOs take it with one parent taking the first 6 months and the other taking the second 6 months when both are RMOs

7. However there is no entitlement for one RMO to split their parental leave, e.g: taking 2 weeks of parental leave, working for a month and then taking another 2 weeks. Some DHBs will agree to this and there is no harm in asking, just make sure you get a commitment from the DHB that splitting the leave won't impact on any other entitlements.

Now we get to the payment provisions, you may receive one of the following options:-

1. If you are receiving government paid parental leave payments then under the NZRDA MECA you are entitled to a "top up". This payment is calculated by taking 6 weeks worth of salary, totalling this amount, dividing it by 14. The resulting amount is then paid to you each week for 14 weeks. If you take less than 14 weeks of parental leave then the balance is paid to you as a lump sum when you return to work.

2. Once you have returned to work from taking parental leave and worked for 6 months then you are entitled to a lump sum payment. This payment is dependent on the number of weeks of parental leave that you took. So if you took 2 weeks of parental leave the payment is 2 weeks worth of salary, up to a maximum of 6 weeks so if you took 7 weeks of parental leave the payment is 6 weeks worth of salary.

If both parents are covered by the NZRDA MECA then both parents receive payment.

Alternative Holidays

Alternative holidays or stat day applications can often be confusing. Depending on how many public holidays (or statutory days) you work, you will get more leave, or "lieu days".

> Your application to use a lieu day cannot be declined. The days in lieu must be either agreed upon with the employer or if this is not possible, a time determined by you while taking into account your employers view on whether it is convenient for them.

Essentially, for each public holiday on which you either work or are on call (which is "work"), you get a day "Time Off In Lieu" – or TOIL as it is known.

The important guidelines to remember are:

You must give your employer 14 days' notice of taking the alternative paid holiday. The only reason provided by law for why you cannot take a day in lieu is if it falls on another public holiday.

Your application to use a lieu day cannot be declined. The days in lieu must be either agreed upon with the employer or if this is not possible, a time determined by you while taking into account your employers view on whether it is convenient for them. If your employer says they have declined this, do not worry this simply means it is not convenient for them, and ultimately you can decide to take the lieu day regardless of your employer declining the leave.

Lieu days are credited in whole meaning you receive a whole working day off work, regardless of the amount of time you actually worked on the public holiday.

If you have any further questions about leave, do not hesitate to get in touch with us.

Case Study: RMO Denied Alternative Holidays

An interesting scenario we have encountered here at the RDA is when we were contacted by an RMO who had been denied using their stat day.

The situation with this particular RMO was complicated because it included both a swapped shift query and lieu leave query. When we enquired further, we found out the DHB had stated they would not allow the RMO to take the day as a lieu day because they had originally swapped that day's work with a colleague.

As you well know, a lieu day can be taken on any day so long as that day is not also a public holiday. The DHB can express that this leave would not be convenient for them, but they still have the duty to cover this leave. Further, this swap had been incorporated into the published roster, and when rosters are amended to honour swapped shifts, this is your official roster and therefore, you are entitled to use your lieu leave on these days.

When we contacted the DHB they initially denied that they were required to allow the RMO to take the day as lieu leave. However, we communicated that as they had published a roster in which they incorporated the swap, this was now the official roster and the RMO had a right to take that day as lieu leave. In the end the RMO was allowed to take the Lieu day as it was determined that this was not a legitimate reason to deny lieu leave.

This is an important situation for RMOs to remember because it highlights your rights and the duty of your employer to accommodate them.

Feature: Part-time Employment Study

It comes as no surprise that work-life imbalance is prevalent among resident doctors due to long work hours and the need to meet training requirements. Residents have been subjected to increased workloads, time pressure and stress, which has led to a higher rate of burnout compared to the general population.

> "The need for part-time employment is present in the healthcare setting, as working long hours is seen as 'normal' and is encouraged, even though it is detrimental to the health and wellbeing of residents."

The issue of inadequate access to flexible employment has been raised to National Resident Doctors Engagement (NREG) and the RDA has undertaken an ongoing study on the subject. Interest in part-time employment has increased over the years; however, few are actually able to pursue flexible employment due to structural and non-structural barriers.

The need for part-time employment is present in the healthcare setting, as working long hours is seen as "normal" and is encouraged, even though it is detrimental to the health and wellbeing of residents. Long work hours leave minimum time and energy for life outside of work. Studies show that the fear of being discriminated against has discouraged residents from pursuing part-time employment. This is due to the archaic view that working long hours is essential; and working anything less is seen as weakness or incompetence. Fear of lack of support from employers, negative attitudes from superiors, and unawareness and misinformation of part-time training and employment are also barriers that continue to discourage residents. This is consistent with the RDA survey findings.

A study reported that flexible employment has no adverse effect on patient outcomes, satisfaction, education quality and overall patient wellbeing. Interestingly, patients have reported higher satisfaction when encountering part-time employees compared to full-timers. This may be due to part-time employees having higher humanistic skills.

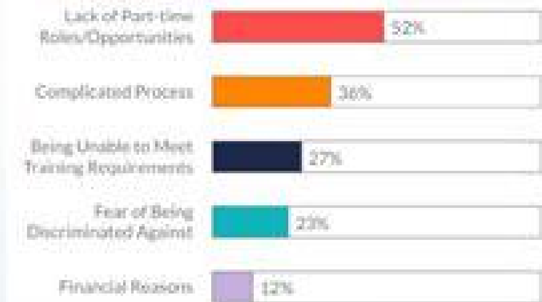
An increase in job satisfaction including morale, enthusiasm and productivity has been perceived by managers and part-time employees themselves. Reduced feelings of burnout were reported due to more time available for rest and a personal life. Part-time employment that allow for a healthy work-life balance has been found to reduce stress, fatigue and pressure.

As for employers, the advantages of providing part-time posts include the availability of more candidates for recruitment, increased productivity, lower rates of staff turnover, and employee longevity. Job satisfaction of staff influences job retention which may eventually result in a decrease in workforce shortage.

The Findings

84% of those surveyed believe that there are barriers to being employed part-time.

Perceived Barriers to Part-time Employment



Perceived Disadvantages

- Negative impact on training (52.6%)
- Patient care (24%)
- Stigma/discrimination (23.5%)
- Financial restriction (20%)
- Overworking (15%)

Perceived Advantages

+ Work-life balance (64.3%)
+ Improved mental and physical health (43%)
+ Increased family time (31%)
+ Increased job satisfaction (17%)
+ Academic reasons (17%)

Case Study: Pilot Emergency Medical Training Programme

A pilot part-time emergency medicine training program commenced in 2017 in the UK. Seventeen trainees took part in this option, working at 80% FTE across 16 hospitals. In the second cohort, an additional 25 trainees joined the program.

An improved work-life balance, job satisfaction and increased likelihood of remaining in emergency medicine was reported. Increased quality of patient care was also observed while the initiative didn't impact the intensity of workload.

Paediatrics and Obstetrics and Gynaecology will be started their pilot training program in March 2020. The pilot allows resident doctors to work for 50%, 60%, 70% or 80% FTE; however, are unable to select days or hours of work as it may change depending on the needs of the department. The aim of this pilot is to reduce attrition, improve morale and increase recruitment and is under the Enhancing Junior Doctors' Working Lives initiative.

Despite the advantages and need for part-time employment, there is still a lack of positions available to accommodate for flexibility and a life outside of work. In order to increase retention and recruitment, medical organisations need to cater to this demand and provide RMOs with flexible employment options.

Increasing flexible employment posts will also facilitate those who are interested in pursuing part-time employment and eventually normalise flexible working arrangements leading to the invalidation of common stereotypes and myths which enforce the infamous unhealthy work-life imbalance within the medical profession.

As a follow up to the survey, we have held focus groups to discuss:

•The need for part-time roles

•Experience of working part-time (including myths and realities)

•Barriers and facilitators of part-time/flexible working arrangements

•Our members' additional wants and needs

References for this article are available on the NZRDA website: nzrda.org.nz/news_posts/the-nzrda-part-time-employment-study/.

On Call Car Parking

With winter months come shorter days and darker nights. As temperatures plunge, we see more rain, hail and for hospital car parks in the south - snow and ice. For those who come and go in daylight hours, it can escape notice the special risks of arriving and exiting hospitals at night.

Clause 36 of the RDA and DHBs MECA requires that "Where space is available, safe and secure parking close to the main entrance of the hospital for RMO's undertaking work during the hours of darkness. Where space is not available the DHB must make appropriate alternative arrangements such as the provision of taxis."

Risks include assault and robbery and trips and falls. Last winter there were a spate of attacks on night shift staff in hospital car parks including in Christchurch and the Auckland region.

Clause 36 of the RDA and DHBs MECA requires that "Where space is available, safe and secure parking close to the main entrance of the hospital for RMO's undertaking work during the hours of darkness. Where space is not available the DHB must make appropriate alternative arrangements such as the provision of taxis."

A variation of this clause has now also been agreed between the SMOs union ASMS and the DHBs, "Where an employee is required to work or is called in to the service during the hours of darkness suitable safe vehicle parking will be arranged and/or arrangements will be in place to ensure that employees are not put at risk leaving or returning to their cars."

Feedback collected for this year's Hospital Review has highlighted the ongoing challenges we face on car parking. During the Covid response, DHBs showed greater willingness to make parking better available for staff including removing charges.

This winter we are going to be doing a stock take on how well DHBs are going to providing those working long days, nights and on call are getting access to safe and secure car parking. If you have any comments, questions or concerns on car parking feel free to get in touch with us at ask@nzrda.org.nz

Change is Coming to a Roster Near you...

Since the beginning of this year we have been involved in a number of changes to rosters across the country as DHBs approve and appoint new FTE and we are seeing more RMO driven roster changes.

Covid-19 has had an impact here, with some roster numbers increasing permanently when additional staff had been recruited to address the pandemic and stayed on, or alternative roster patterns were developed as part of the pandemic response and were found to be an improvement that warranted becoming the status quo.

We agreed with DHBs that the crisis or disaster rosters implemented at the beginning of the pandemic should revert to pre-Covid patterns once things started returning to normal but where these rosters were preferred to the original roster, some RMOs have moved and are moving to make the change permanent.

In other departments the changes were being trialled or discussed prior to the pandemic and have now progressed to the stage of implementation.

Some of the rosters where we are seeing recent improvements are:

Northland DHB General Medicine registrar

With additional registrar numbers it is finally possible to implement a long-planned roster with higher levels of cover after-hours. This roster does have a swing shift (1400 to 2200) which on the downside can restrict teaching opportunities.

Waikato DHB O&G registrar

Again with a desire to increase the level of cover after hours, the registrars have initiated a move to a roster that sees two registrars on nights (as opposed to a single registrar) and voted to commence a trial of the new roster.

MidCentral ED House Officer

To address a number of issues with the existing roster, RMOs at Palmerston North designed a better ED roster compliant with requirements for sleep recovery days, no more than 30% night shifts and no more than 1 in 3 weekends. The DHB had commenced the voting process to determine the preferred new roster when Covid halted progress but we will be asking for this to get underway again.

Auckland Region

A number of change processes were underway and were temporarily suspended due to Covid, but are now recommencing. These include:-

- a trial that was be carried out on the ADHB O&G registrar run where the RMOs had requested an alternative placement of shifts to reduce fatigue
- two more SHOs on the Anaesthesia run at Middlemore Hospital
- a trial at Waitemata DHB increasing the levels of cover on the O&G registrar roster after hours
- A new House Officer NICU role at CMDHB

Canterbury General Medicine

A new roster has been proposed and implemented with a higher number of acute teams to address a number of issues that had been raised including:

- Advanced trainees meeting training requirements
- Workload and frequency of "on-take" and "take-over" teams
- Insufficient acute staff on during the evening

Although there are some compliance issues with this roster we will work with the DHB to get these resolved before the busy winter season.

If you and your colleagues would like to initiate a change on your roster, now would be a good time to get this underway. Covid has highlighted the urgent need for additional capacity on RMO rosters in general medicine, ED/ICU, anaesthesia, and in fact across almost all DHB medical/surgical services. As we head into what will undoubtedly be another hectic winter, take some time to assess whether your roster has sufficient staffing and/or whether the roster pattern is safe.

We can help you through this process if you get in contact with your delegate or email ask@nzrda.org.nz

Understanding the STONZ MECA

We have noticed that SToNZ has agreed with DHBs that under their MECA there is no entitlement to additional duties for the after-hours component of shifts where you do not get at least 28 days' notice of the rostered shift.

Obviously this does not apply under the RDA MECA. Under the RDA MECA if you are not provided 28 days' notice of your rostered shift, additional duties have always been paid, and must continue to be paid, as minimum compensation for the breach of the roster notice requirements of our MECA.

When we renegotiate our MECA with DHBs early next year we will undoubtedly want to address issues of RMO remuneration. However gaining a salary increase should not come at the expense of other provisions in our MECA so in order to make an informed choice of what we might face.

In just eighteen months SToNZ have already given away the following protections for RMOs under their MECA:

- Maximum of two long days in seven days.
- Maximum of ten days in a row on acute on duty rosters (sch 10).
- Maximum of four nights in a row on acute on duty rosters (sch 10).
- Maximum of 16 hours work.
- Maximum of 72 hours work in any consecutive 7 days.
- 80 days of sick leave per PGY1-4s.
- Prohibition on cross cover outside ordinary hours.
- Requirement that allocations be part of an RMOs training programme.
- Requirement to have every second weekend free from duties.
- Three hours of protected teaching time per week for house surgeons at Waikato, Taranaki, Hawkes Bay, MidCentral.
- Four hours of protected teaching time per week for house surgeons at Tauranga, Lakes, Whanganui, Wairarapa, Hutt Valley, Capital and Coast, Nelson Marlborough.
- 12 weeks of medical education leave for dual trainees.
- Run descriptions change only with 2/3rds agreement of RMOs.
- Payment at additional duties if less than 28 days' notice of roster.
- Lump sum parental leave payment for non-primary caregiver (often fathers).
- 12 months of unpaid parental leave for non-primary caregiver (often fathers).
- 28 days' notice of rosters for relievers.
- Payment at 2 categories above for embedded relievers.
- Payment for sleep recovery days.
- 30% limit on night duties for ED/ICU rosters.
- Additional duty rates for public holidays at Bay of Plenty, Whanganui, Midcentral and Tairawhiti DHBs.
- Reimbursement for College exam fees after third attempt.
- Relievers cannot be used to supplement staffing levels and cannot be reassigned without their agreement.
- Ability to have a run review every season.
- Right to no more than one weekend in three at Tairawhiti.
- Having abutting weekends free of duties when taking medical education/ conference leave.
- Additional duties when covering an absent colleague between 0700 and 0800 and between 1700 and 1730.
- •An additional days' leave when public holidays fall on sleep recovery days and weekend RDOs.
- Teaching time and medical education leave for locums.
- Reimbursement of indemnity insurance for locums.
- Safety and supervision requirements for PGY1s working in EDs and ICUs.
- Night shift protections for PGY1s at Northland, Waikato, Midcentral, Whanganui, Tairawhiti, Lakes, West Coast and South Canterbury DHBs, as well as Nelson and Invercargill hospitals.
- Protections on rotating RMOs to DHBs outside city limits.
- Requirement that on runs outside the DHB setting, RMOs remain DHB employees.
- Requirements to reimburse part time employees APC, indemnity and costs of training.
- Minimum break provisions after a call back duty less than 8 hours. A minimum two sleep recovery days after three consecutive night shifts.
- Payments for emergency backup rosters.
- Meals not being changed without agreement.
- Cross cover paid per shift.
- Higher rates of cross-cover at Nelson Marlborough, Bay of Plenty and Northland DHBs.
- Case by case assessments of any salary reduction for pregnant employees.
- Ability to take two weeks leave to complete the diploma of O+G or paediatrics without the clinical lead's approval.
- Additional conference leave for registrars with more than ten years' service.
- Requirement for Waikato and Lakes ED RMOs to have 3 weekends in 5 off duty.

Changing the Start of the RMO Year

There has been communication recently about once again looking at moving the dates of the training year. What follows are some comments from members about the pros and cons of changing and also raises questions about the change.

ISSUES	FOR	AGAINST	QUESTIONS
TIs financial disadvantage and/or extended holiday	Throughout the entirety of the TI year there are 2-4 weeks holiday and many start work feeling stressed with a week spent moving their entire lives around the country after a busy and stressful year at medical school. The lack of holiday was a contributing factor to the elective issues highlighted last year. For other professions, job security after graduation is not guaranteed. Many young professionals wait to start their jobs in the new year, that is if they have secured a job prior to completion of their university whereas RMOs are guaranteed a job on graduating from medical school. The main reason many House Officers choose not to take leave in their first month of employment is because: a) they think it wouldn't be approved, and b) thought it would look bad taking a holiday within the first few weeks of working. RMOs report feeling that a holiday prior to starting employment would have been very beneficial.	The first few weeks after graduation are busy, but that is the unavoidable reality of a transition to a new job, quite possibly in a new city. There is definite merit to starting work during the quieter summer season. If trainee interns want more time to relocate, then pressure should be put on the universities to finish up their trainee intern final semester a week or so earlier. Many trainee interns will have financial pressure and feel that most would be keen to start work when they currently do, rather than waiting at least six unpaid weeks until the new year. If there was a gap, many who aren't able to afford a holiday will be in limbo as neither a fully registered doctor nor student so may have to pick up a random summer job in competition with other students on their holiday break. If you consider the delay period as 8 weeks of leave without pay which is pretax $13,800 (8 weeks of $90k salary), then the TIs may need some other sort of compensation or remuneration for the period. There are a considerable number of TIs who are providing for their families or living independently for whom 'a holiday' before working is not applicable to them. NZMSA have canvassed trainee interns before and they were against it. This is instructive, and suggesting they have a 'holiday' probably sits somewhere between misguided paternalism and expectation of privilege. Even that 3 weeks (after TI grant stops) prior to the first pay as a PGY1 is financially tight for some. Particularly on those coming back from Q4 elective and those with families or other commitments, but even just on the average new HO. Lots of new bills come up around then for PGY1s, such as trying to afford flights down to grad, MCNZ payments, Christmas etc;	Have the universities stated their position with regard to wouldn't extending or adjusting the TI year to match a later changeover date? If the university decision is to extend the training year will the payment also increase? Although a holiday may be preferable before commencing employment how many TIs could afford it?
Run Orientation	Despite electives/outpatients being closed down it can be hard to establish routine and team structure over the holiday period. Starting a new job right before Christmas during what is a incredibly disruptive period can result in a loss of momentum with training (especially surgical, as most SMOs take leave and elective services/surgery wind down). It is more difficult in December to track down consultants for start-of-run supervisor meetings because everyone is starting to go on leave. Further to this with a raft of stat days, staffing is usually very lean which is even harder if you are junior or new to a hospital.	This "acutes only" Christmas period allows those new to the role to acclimatise in a less stressful period as opposed to being new when the hospitals are at full throttle, as they are by February. Furthermore, a delay in starting in new roles gives less time to up-skill as the year gets busier towards the winter period. Better to have started in November/December 7 months ahead of winter, than January/February with only 4 months experience before winter hits and is closer busy exam time. The quieter period allows house officers to get to grips on the basics before the onslaught of wintertime craziness, and provides space for extra registrar to HO informal teaching which is invaluable. December is the quiet season for hospitals with less medical adult and paediatric admissions, less elective operations and with no medical students or TIs to supervise. This has benefits for both PGY1s and first year registrars as they 'step up'.	Is it better to start a new run when work is quiet or when work is busy?
Supervision	The current system combines the risk of new PGY1s with the risk of reduced holiday staffing. The current apprenticeship model of teaching in medicine requires senior leaders to be present teaching and supervising. Over the Christmas many things regarding supervision are difficult to organise and complete, because of the sheer demands on completion of the year by SMOs and decreased time within the hospital at a busy social outside of work time.	If the Christmas-New Year's staffing is not safe for first years, this indicates an underlying problem that needs redress rather than changing the year. Newly minted surgical fellows tend to locum over summer to cover SMO leave prior to starting their overseas fellowships. This is the first taste of truly independent practice in a low stress and low throughput environment.	There needs to be a balance between fewer patients so less workload and less supervision being available due to leave being taken, which has the greater impact on the PGY1 experience?

ISSUES	FOR	AGAINST	QUESTIONS
Leave	You almost never get Christmas leave confirmation until it's too late to arrange/organise anything because "it's the next run".		Is this a leave issue that needs to be addressed outside of changeover issues?
Accommodation/ children	It was stressful for TIs to find accommodation 1 week after finishing university. Many end up sleeping on couches, house sitting or staying with friends until after Christmas when rental properties came available. Changeover in November is incredibly difficult for RMOs with children, particularly if they are in school or childcare with these places closing over the holidays.	It may be more difficult to find accommodation when competing with people in the new year – students etc.	Why will it be easier to find a rental in January/February?
Aligning with the Australasian year	The opportunity to work in Australia, gain a new perspective and experience which can then be brought home and added to practise here in New Zealand is not something that should be disregarded lightly. The lack of alignment between training years makes the move very difficult and delays progression through training (if missing out completing a full 12 months training in a given year). The number of RMOs moving between the two countries is small because the non-aligned training years makes it difficult to do so - if the years were aligned, it would potentially open up more opportunity for NZ RMOs to access valuable training experience in Australia. Moving there is fine - holiday or locum for two months. But returning results in either ending the Australian job two months early or starting the NZ job two months late. The result is only 10 months of training counting in one year, which for some colleges would mean having to do potentially several extra months to "catch up". This move makes huge sense for the Fellows and sub-specialty roles that NZ simply doesn't have the patient numbers to sustain training for, however there are many who go to get experience prior to choosing a training program, to locum, to work and experience a different health system or culture or who may be pulled for a short time for family reasons.	A tiny fraction of RMO's seek to work in Australia in their first couple of years of practice, making any plausible benefit of alignment negligible. For the more senior RMO's who are trying to get on to fellowships in Australia, they can manage any possible misalignment just fine. Most of the Australian RMOs complaining about their change over time (first week Feb) and it is incredibly disruptive for exam preparation - Colleges moves RMOs around an area for training every 6 months (area could range from all of Queensland or little as a few hospitals in Sydney) so moving house and arranging leave etc then. Movement before FRACP exams, CICM exams and I think FRACS exams early in the year is not ideal.	The TI start date does not have to be the same as registrars, or all registrars for that matter. TIs could start in Nov and Regs in the new year and medical registrars could start at a different date from anyone else so long as it is after the house officer commencement date. Quite a few house officers move to registrar posts in June/July and August/September currently. At some stage however, there would be a loss in pay – in the case of those transitioning from house officer positions to registrars it would be these house officers and thereafter these registrars would earn less overall as each annual increase would be delayed by three months.
NZ RMO to SMO Pipeline		The marketplace affecting the RMO workforce adapts very quickly and NZ's main competitor is Australia. It was not that long ago that upwards of 20% of the RMO workforce was being targeted by Australia: the earlier start date secured a home-grown workforce giving a critical advantage. Doctors are privileged with relative job security after graduation and receive a huge financial investment from the country during medical school and specialist training. The end goal for the health and education system is fellowship trained specialists, not perpetual HOs or MOSS's. NZ only based training programmes such as general practice and rural hospital medicine that would be significantly disrupted by moving the changeover date. Rural Hospital Medicine in particular blends a mix of primary care and hospital based placements.	How many RMOs do go to Australia? How many stay?

Run Review 101

A common question we get asked here at the RDA is "how is my pay calculated". The NZRDA MECA calculated pay is unique to RMOs and is worked out through run reviews which establish whether a run category accurately reflects what you are working.

So how do we calculate which category your run falls into?

Run reviews can be undertaken after a request from either you, or the DHB and involve keeping time records for a specified period. To ensure you're paid a fair rate, there are certain times throughout the year we recommend not initiating a run review, extended public holidays and exam time often don't reflect actual hours worked and it may disadvantage you if you trigger a run review in one of these periods.

Using your timesheets from this 4-6-week period, average un-rostered hours are then worked out by calculating weekly average overtime for the sample period (e.g. all the time when you stay past your rostered finish time). We then add this figure to the normal or ordinary hours, which, for most RMOs, is 40 per week, but for ED and other runs can be 45. Total rostered hours over and above the initial 40 or 45 are then worked out by averaging the length of the shifts worked over 8 hours across the run.

We then add these three numbers together to get your average hours worked in a week and place you in the right category. If you're on a run where people are taking a lot of annual leave this doesn't affect how much you get paid. We factor this into our calculations to make sure you're getting paid the correct amount.

To help us achieve the best rate of pay we can, make sure you're filling out your time sheets correctly.

Public Holiday pay is another interesting part of the MECA that is unique to the agreement. There is a formula in the MECA to work out what your time and a half rate is which at first glance appears a bit confusing.

Clause 18.3 reads:

"The calculation of T1/2 and relevant daily pay shall be made as follows: The employee's annual salary as set out in clause 8 will be divided by 52.14 and then the lowest number of hours per week to which the salary category relates. The resulting figure is then halved and this becomes the additional payment to be made per hour worked over and above relevant daily pay."

Example:

If you're a first year house officer in category B of the pay scale, your time and a half pay would be worked out as:

(93772/52.14)/60 = 29.97

29.97/2= 14.99

This rate is then paid to you on top of your base salary for each hour worked on a public holiday.

If you have any questions about your pay, please don't hesitate to let us know.

Health & Safety

A Quick Guide to Proper Handling and Disposal of Needles

Needle and syringe safety are an important part of RMO health and safety at work.

Rule #1 is to safely dispose of the needle and syringe as a single unit.

Several international jurisdictions ban the use of "De-notching" (manually removing the needle and disposing of it separately) due to the health and safety risks associated with it. However, this does not include the Pronto quick release system nor any needle which has a safety device cap.

The World Health Organisation (WHO)'s position is, "The best practice is to discard the needle and syringe, or needle and tube holder, as a single unit, into a sharps container that is clearly visible and within arm's reach. The size of the container should permit disposal of the entire device rather than just the needle".

What should you do if your employer has any policy other than single unit disposal?

If you choose to, you may refuse to comply with the "de-notching" instruction, and continue to dispose of the entire unit intact, since the instruction to de-notch needles is not a lawful order.

You should carry out your duties in a manner that you feel is safe, and not a risk to your health and safety. If you choose to refuse to comply with the instructions, you should inform your HR Manager so that the matter can be put on record.

In the event of a needlestick injury, if you have refused to de-notch, Worksafe will be informed since staff are already on record saying that they do not feel safe. If an RDA member is subject to any form of action on this issue, a Personal Grievance process will be initiated by RDA on behalf of the member.

Needlestick injuries

- In a survey conducted by Waikato DHB in 2011, a total of 123 surveyed reported 1 or more needlestick injuries within a period of 12 months.
- A survey conducted by SERMO in April 2019 across six countries, surveying 510 surgeons, revealed that 95% of surgeons had either experienced a needlestick injury or witnessed a colleague sustain one.

In one case, a Health & Safety manager told staff that reporting to WorkSafe was only required if the receiver of the injury contracts an infection. However, this is incorrect. The exposure to human body fluids has its own category, requires medical intervention (a blood test), and must be reported.

What can you do?

Inform your employer immediately of the hazard so they can address it. For issues related to the handling and disposal of needles, contact Human Resources, and speak with an RDA advocate. We want to know immediately if you are challenged for refusing to unsafely de-notch.

CONTACT DETAILS

nzrda.org.nz/contact/

Membership	membership@nzrda.org.nz
General & MECA enquiries	ask@nzrda.org.nz
Superannuation	superannuation@nzrda.org.nz
Insurance	insurance@nzrda.org.nz
NZRDA Education Trust	educationtrust@nzrda.org.nz

Phone: (09) 526 0280
Free phone: 0800 803 993

facebook.com/nzresidentdoctor

Unit E, Building 3
195 Main Highway, Ellerslie
Auckland

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