Who are my delegates?

Do you want to know who your local delegate is? We have an updated list of our delegates post change over on the NZRDA website. Go to www.nzrda.org.nz click on the ‘About’ tab and then ‘Our People’ to view the full list. Delegates are there to provide support and advice to all of you and are a first point of call when you have a MECA query or workplace issue.

How do I become a delegate?

If you are interested in becoming a delegate we suggest you talk to an existing delegate or contact the NZRDA office for more information. As a delegate you are likely to develop negotiating and problem solving skills, hold meetings, help others less able to speak out and have a real say in the future direction of the medical profession. You will also be able to attend the annual 4-day Delegates Training. Next year in March, Delegates Training is taking place in Tauranga.

MCNZ proposed fees

In May we emailed the MCNZ proposed fee structure document to all members and requested your feedback. We summarised the feedback received and submitted this to the MCNZ on behalf of RMOs. You can read this feedback on the NZRDA website. Go to www.nzrda.org.nz click on the ‘Hot Topics’ tab and then ‘MCNZ Proposed Fee Restructure’.

The flu vaccination and mandatory mask wearing

This winter flu rates have reached epidemic levels across New Zealand and over the last few months the DHBs have been approaching all of you to get vaccinated. Most of you will now be aware that Waikato DHB has chosen to enforce mandatory mask wearing amongst its non-vaccinated staff. A handful of employees have been suspended and one has been dismissed for failing to comply with these requirements. What follows below is a brief run down of the situation which includes some insight into the role of the NZRDA (past and present) in regards to Waikato DHB’s mandatory mask wearing policy.

Background

The issue of vaccinations and the flu vaccination in particular has been on our agenda over the past few months, as it has been for our sector. In 2015, despite improved uptake of the flu vaccination amongst DHB employees, one DHB (Waikato) has continued to adopt what is perceived to be a punitive approach to non-vaccinated staff, insisting that they wear masks when in direct patient contact or otherwise risk suspension and disciplinary procedures.

Role of the NZRDA

We felt at this time it might be appropriate to discuss the role of the Union in this matter. Amongst our membership we have the full spectrum from those passionately in favour of vaccinations, to those equally against. So should the RDA even have a view and if so on what basis?

We first became involved in this matter over a year ago as a result of one DHB (not Waikato) circulating a draft vaccination policy, which included the intention to seriously disadvantage employee's employment if they were not vaccinated. This “disadvantage” was not simply wearing a mask, but could have also resulted in redeployment and possibly the dismissal of an employee who refused vaccination. This policy had been motivated by a passionate belief in the role of vaccinations to protect patients; children from whooping cough and the like. Whilst their motivation wasn’t questioned, the failure to consider wider implications, including individual’s rights fell well short of the mark. We were not too happy about that approach, which lead to both an “oh no you don’t” but also some further investigation of the issues at a national level by both unions and DHBs through a known as NBAG.

Right not to be vaccinated

So starting with the right not to be vaccinated - we all have that right. Being injected against our will is assault, pure and simple. In addition, when in receipt of healthcare, everyone is covered by the HDC Code of (patient) Rights. This provides for the right to informed consent and the right to say “no”. It also provides for the right to be treated with respect. Given one role of a union is the legal protection of member’s rights, enforcing the right not to be vaccinated goes without question.

The issue of vaccination largely comes down to an individual view (I do or I do not wish to be vaccinated because I...) or a collective one. On the latter, there is both a public health good derived from vaccinations and an employment one. The former relates to the reduced spread of disease and therefore harm, especially amongst those in our communities who are most vulnerable, and the latter, lack of staff to treat the sick due to staff themselves being sick. And yes, for the DHBs less sick days resulting in reduced cost is attractive.

The vaccination

Evidence confirms that whilst not a perfect remedy, vaccination is the best mechanism we have to prevent the spread of disease and the human toll that disease represents. Herd immunity, where vaccination rates are high enough to stem the spread of disease and therefore protect a community, is the goal. The drop in vaccination rates in Canterbury and resulting outbreak of measles is a perfect example. Measles is another nasty virus that causes serious and life threatening disease, with that outbreak resulting in dozens of young people being admitted to ICU with encephalitis and the like.

Approach to the issue

When the unions and DHBs (in the forum known as NBAG) collectively came together to investigate the issue what became clear was that a positive, educative and supportive approach to the issue of vaccinations was far more successful than punitive, threatening or negative. If the overall motivation is community good through protection from disease, having people “on board” is going to be more effective than the resistance a
negative approach inevitably engenders. This is not so much about vaccinations per se, but about how we approach the issue.

Acknowledging that employees can’t be required to be vaccinated, what about the DHBs ability to decide what to do with the non-vaccinated staff? In fairness NBAG didn’t even go there (at that time). We agreed a positive and constructive approach was better and looked (amongst other things) to whether the Unions had a role in leadership on this issue, thereby in effect avoiding a negative reaction that some DHBs might have in the face of non-vaccination. The answer was yes: better to keep members out of trouble whilst recognising that everyone has rights. NBAG put out guidelines to the DHBs supporting a positive and educative approach, rather than a punitive one. And the unions agreed to support engagement with members on this issue.

For our part we surveyed members views on the issue and provided further information as required. In Northland DHB we embarked on a case study to determine whether our member’s active engagement had any material effect on vaccination rates. The answer was yes: with members from the labs, radiology and resident doctors recording higher vaccination rates (between 74% and 90%) than those in the DHB overall.

So far so good. Unions avoided the punitive and inevitably adversarial approach DHBs might take against members: DHBs got support on the vaccination process, accepting that some of our members would not (agree) but as herd immunity was the goal we would get there anyway. A quiet note here... for all the DHBs expressed concern, the percentage uptake amongst management wasn’t different from the rest of the staff, confirming that we are dealing with a wider and more intrinsic issue than superficial review might suggest.

**Failure to consult**

So why did Waikato ignore NBAG advice and fail to engage with the unions on the issue? Well, Waikato DHB has an already evidenced poor culture when it comes to employee engagement, so probably no surprises there. It is sad, but this DHB continues to have a poor attitude towards their own employees on a number of fronts, including bullying. And again, regardless of personal “pro vaccinations” or not views, members have been almost universally concerned at how Waikato DHB is handling this matter.

We have made a joint application to the Employment Relations Authority to test the DHBS policy on the basis of a failure to adequately consult prior to implementation. Not only is the issue of ignoring considered national advice on the matter concerning, a whole lot of other issues have arisen that, had proper consultation occurred, would most likely have been worked through.

**Unresolved issues**

A number of issues do need to be resolved, including:

- What other measures did the DHB take to increase vaccination rates before resorting to the enforcement of mask wearing?
- What is “direct patient contact”?
- How effective is mask wearing, including how often we need to change masks to be effective?
- What of the effect on patient - staff communication through a mask?
- Distribution of personal health information (vaccination status is health information).
- What of patient and visitor vaccination status? Visitors can equally spread the virus (remembering the flu is communicable up to 14 days prior to symptoms emerging) so what is the point of just concentrating on staff?
- If the patient is vaccinated, should the staff member have to wear a mask?
- If such a public health issue, consistent application of measures are surely required? If that means short staffed areas being left without staff and services interrupted as a result, what is the balance between non vaccinated staff on duty and no service?

We could go on... Waikato’s approach is also causing resistance amongst staff, and could be self defeating. It is also exacerbating a prevalent negative culture in this DHB which is corrosive, damaging to staff and in need of change. All of these issues are of concern to us and our members.

**NZRDA involvement**

So in summary... why is the RDA involved in this issue?

- Because members have rights and we are tasked legally with preserving those rights.
- Because we also have a role to play in avoiding conflict and progressing matters on an evidence based and reasonable basis.
- Because Union leadership is evidenced as being instrumental in assisting with positive change on issues such as this (and our own experience supports this).
- Because at the end of the day our members want what is in the interests of not just themselves but their patients and communities. However as with most things in health, this is a more complex issue than a superficial glance might suggest, and we need to do the best we can to get it right.

If you have any queries, concerns or comments in regards to the above please do not hesitate to contact the NZRDA office at delegate@nzsda.org.nz.

**Cover for absent RMOs**

Cross cover outside of ordinary hours is a not an uncommon occurrence and usually arises as a result of poor DHB leave systems. It is important that you as an RMO are aware of both your rights under the MECA in regards to cover generally and also the contractual responsibilities of the DHB in regards to managing leave and finding cover. The DHBs have a number of leave options available to them when trying to find cover.

**Introduction**

Cross cover is where one RMO covers for an absent colleague during ordinary hours. Registrars may cross cover for House Officers but a House Officer should take care in agreeing to cover for a Registrar. Cross cover is voluntary and is remunerated at $150 per day as a minimum. Cross cover outside ordinary hours (XCOOH) occurs where an RMO who is rostered on outside ordinary hours (ordinary hours being 0800 – 1700) is absent and another RMO already rostered on duty is asked to cover both duties. Cross cover outside ordinary hours is prohibited under the MECA. Why? It is unacceptable to ask (or leave) an RMO to do more work at a time when there is minimum staffing available. If an RMO is absent then the employer must supply a reliever or a locum to cover the duties.

The causes of a DHB’s failure to cover leave (often resulting in XCOOH) are...
primarily due to administrative and resourcing inadequacies. This includes for example, a failure to update rosters, a failure to maintain enough locums and a failure to employ enough relievers.

Need for RMOs to have access to leave

The need to ensure RMOs get access to leave and not be hesitant in applying because it is 'always such a fight' is self evident. Leave (from both parties perspectives) is an entitlement that provides for rest and recuperation better enabling doctors to return and continue their duties in a refreshed manner. RMOs carry an immense amount of responsibility for patient outcomes, exert high levels of physical and intellectual labour and can be adversely affected by fatigue and work overload. Adequate rest and recovery is essential in this environment.

Responsibility to arrange appropriate cover lies with the DHB

Clause 16.1 of the MECA provides that the responsibility to arrange cover for RMOs lies with the employer and that it is not the responsibility of individual employees to find cover for their own leave. A DHB declining leave unless an RMO concedes to breach the MECA (taking on the responsibility to provide cover) undermines the MECA provision and is unacceptable.

Clause 16 also makes clear that the employer must take all reasonable steps to ensure sufficient cover is available to permit RMOs to take leave (both planned and unplanned) - this is a contractual obligation imposed on the DHBs. It is not good enough to provide insufficient cover and then use that to justify declining leave. Cover for leave may be provided by relievers, by payment of additional duties or by some other means such as using locums.

Clause 17.2 states that where an RMO is absent from a roster outside of ordinary hours in an at least equivalent replacement suitably qualified medical practitioner (filled in a like for like manner). It also states that not in any circumstance, is the cover to be left to the remaining RMOs rostered on during the period to cover the absent employee's duties in addition to their own.

**TYPES OF COVER OPTIONS**

There are different types of cover options (each with pros and cons) available to the DHBs.

**Relievers**

Firstly and most obviously, relievers. Relievers should provide for the mainstay of leave cover. As a rule of thumb there should be 1 leave reliever employed for every 5 to 6 Registrars and 1 for every 7 House Officers. Note that although many DHBs believe that relief positions cannot be recognised for training (including at a House Officer (MCNZ) level), this is not the case. Whilst some work needs to be done to gain accreditation it is possible.

**Additional duties**

The use of additional duties is voluntary as described in the MECA. If relying on the use of additional duties as a means to provide cover for leave the employers must have a reasonable degree of certainty that this will provide sufficient cover. So if RMOs are routinely declining additional duties on the basis that "if does not pay enough" then the DHB either must find another way to provide cover or pay more. Additional duties works better if arranged in advance as opposed to being reliant at a short notice ‘ring around’.

**Short notice leave relievers**

Short Notice Leave Relievers is a function of the leave reliever's protocol which is scheduled at the back of the MECA (only 4 DHBs (Auckland, Counties Manukau, Waitemata and Southern) have signed up to this). The protocol reduces the normal reliever notification of roster time to 14 days (as opposed to 28 days) and allows for same day cover within ordinary hours for those planned relievers not allocated on that day. It also provides for short notice leave relievers to be employed.

**Internal leave cover**

RMOs on the roster agree to cover for each other in the event of some specified quantum of leave being taken by their number. Payment is made by way of salary acknowledgement or negotiated hourly rates of pay. This type of internal leave cover can work for subspecialist registrars with a small number of people on the roster.

However, an internal leave cover system inevitably collapses when attempting to be applied to acute or larger rosters.

**Emergency back-up roster**

These provide for RMOs to volunteer to be available in case they are required for emergency cover. A $50 payment is paid to hold the RMO available or if called back then the call back rate will be paid. This particular roster does not attract many volunteers. Care needs to be taken to ensure their use does not reduce the availability of RMOs to perform other normal duties.

**Relying on a ‘ring around’**

If using this approach a DHB would need reasonable certainty that it will be successful. Reliance on this method would at least require the pool of those being rung to exclude those who can't (work) and still being sufficiently large to provide some surety of success.

**Relying on SMOs**

This option is fraught with problems. The SMO must be prepared to do the work of the RMO, SMOs will likely also have worked or be working at their own job. Whilst it is may be not be stipulated in their MECA, expecting an SMO to work in a manner that for health and safety reasons is deemed unsafe for an RMO is probably not a robust alternative.

**Locums**

Reliance on this particular method would require there to be a sufficient pool to provide a reasonable degree of certainty of cover and that in turn would require the DHB to provide reasonable certainty of work and appropriately attractive rates of pay for the locum(s).

**Final points**

You all already work long hours and work life balance is important to you. RMOs more often than not, resist working long hours. RMOs cannot undertake additional shifts that breach limits on hours and the additional duties rate is hardly an incentive for most RMOs.
Remember, it is the responsibility of the DHB and not you to provide cover for leave. When you agree to work cross cover or additional duties you are assuming accountability for performing those duties safely from a medio-legal perspective.

The MCNZ does not accept ‘tiredness’ as an excuse for making a mistake. So if you feel that it would not be safe to perform the cross cover duties then you must not hesitate to decline. If you have any questions, comments or concerns in regards to the above please do not hesitate to get in touch with us. You can email us at delegate@nzrda.org.nz.

AN UPDATE ON PREVOCATIONAL TRAINING

You will no doubt all be aware of the MCNZ’s changes to the 1st and 2nd year house surgeon’s requirements to first gain general registration and then to maintain that registration as a second year. As part of that process a new e-portfolio has been introduced and as of this coming year, community attachments will start to become available. The intention is that 10% of second years will undertake a community attachment in 2015, increasing to 100% by 2020.

Community attachments

First we should note that one community attachment in our first two years as a doctor will be mandatory as at 2020. Whilst this can be completed as a first or second year, at this time it is envisaged only second years will have access.

The MECA provides that you will remain employed by your DHB whilst on the community attachment and that the terms and conditions of the MECA will continue to apply. There will be some changes – we have made the point that anything less than a C category will not be tolerated, so some weekend and evening (but not night) work back at the DHB may be required.

In terms of what these attachments might look like... well at this time there are a number of “categories” being talked about and trialled:

General Practice

It is clear that house officers will be working not watching in these GP roles. There will be an orientation period, followed by supervised patient consultations through to independent (but report back to the GP) consultations. Protected educational time plus the opportunity to follow an area of interest (such as community paeds diploma and rehabilitation medicine) should be included in the attachment.

We are unsure where the GP placements run out of the RNZCGPs will fit into this. We have made the point to the funder (HWNZ) that whilst a rewarding clinical experience, the stipend arrangement associated with these runs is not (rewarding). With runs now being provided through DHBs we would expect the PGGP runs would be absorbed back into DHB employment but this has not yet been confirmed so we are watching this space. We have also asked that the HWNZ money currently being spent on this become contestable and targeted, so for instance to assist with travel and accommodation for those interested in a rural placement at distance from their home.

There is a level of concern that with house officers entering the GP space, insufficient capacity exists for medical students as well as GPEP registrars. Whether this is the case or not has yet to be seen however one thing is clear: the value of having a house officer or registrar who will earn money for the practice with much less supervision, is higher than a student. On the flip side, this potential to generate income for the practice needs to be monitored to ensure RMOs are not “abused” and that the experience is a genuine training one.

We will need to monitor how this all goes and will be asking you to give us specific feedback on your experiences. With only a few attachments available at this time, we expect everyone to be on their best behaviour, so would be very concerned to hear to the contrary. For those of you participating, please let us know how you get on.

Emergency Care

The NZ College of Urgent Care (as opposed to Australasian College of Emergency Medicine or ACEM) operates in the A & M clinics primarily in the upper North Island. They have a comprehensive training programme and are keen to have RMOs work in their clinics. Again the potential for abuse, given you will be a cheap (paid for by the DHB) source of labour, is being monitored but so far at least this college appears genuine and committed to a good experience.

Where the cut off lies between community based A & M clinics and ones run literally next door to the Hospital ED, such as in the case of Whanganui, is yet to be clarified.

Hospices

Hospices have express an interest in having house officers. No matter what you end up doing, having palliative care experience is probably going to be beneficial, so this is not solely for those with an intended career path in palliative medicine.

Integrated care

The integrated care space is an interesting one. This is where you would be working in the community, reporting to and supervised by GPs but have a patient load of chronic conditions patients (respiratory, diabetes, cardiac etc.), maybe even the frequent fliers. The intention is to keep these patients out of hospital, treating them closer to home in the community. GPs often don’t have the time to do a thorough workup so to have House Surgeons available would add benefit especially if your work kept the patients “weller” and not deteriorating to the point of hospital readmission. Dual supervision with a hospital specialist could be appropriate as well as your own allied practitioner team e.g. for diabetes a podiatrist, pharmacist and dietitian.

In addition, opportunities in rural hospitals and communities e.g. Kaitaia, Ashburton or Tokoroa are also under discussion as well as aged care and mental health community teams.

If you have any questions or feedback in regards to prevocational training and community attachments please do not hesitate to email us at delegate@nzrda.org.nz.