NZRDA

PRESIDENT'S REPORT

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RDA

skill
knowledge
care

presented at the
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Tēnā tatou katoa

Tēnā tatou katoa. Nau mai haere mai ki te Hui a Tau o te New Zealand Resident Doctors' Association mo te tau 2017. Welcome everyone to the New Zealand Resident Doctors' Association Annual General Meeting for the 2017 year.

I stand here today both with sadness and pride as I give my last President's Report for the NZRDA.

This is my tenth year as a member of the NZRDA, and what an amazing 10-year journey it has been. I've lost count of how many rounds of bargaining this included, but we have completed a full cycle from claims-based bargaining to interest-based bargaining to claims-based again. We've been through three strikes, the shock of an employer's 'ideal' contract when they tabled their Greenfields MECA, media campaigns, TV advertisements, the evolution of Facebook (and learning how to use social media during bargaining), and learning what not to say during a bargaining process. We've also had a a 25-year reunion, a conference, a move from our old home in Dominion Road to our space in Ellerslie, an increasing focus on RMO wellbeing, a drive to reduce and eliminate bullying, improving our relationships and communication with the other players in health . . . I could go on.

The NZRDA is one group of very dedicated members and staff; it appears little is out of our reach. I have always felt extremely grateful being an RMO in New Zealand, having the support of the NZRDA, and sharing the strong united voice of our RMO workforce. I, like you, was fortunate enough to start working under a MECA with terms and conditions that had been hard fought for by our predecessors. "Always leave a place better than you found it" is a motto I work by. The commitment, courage and dedication of the RMOs I've worked with over the years have without doubt allowed that to happen. There was sweat and there were tears, but I'd do it all again in a heartbeat. Just look at where we are today.

Membership

A union is only as strong as its members. NZRDA has always enjoyed a strong membership both in numbers and collective voice. Our membership did not see as much growth in numbers this year compared with 2016, but given the strike action around the 2016/2017 changeover causing a spike in membership at that time, this is not surprising. We have always seen a sharp increase in our membership around the time of strike action. This is encouraging as it tells us that what we are fighting for, and willing to strike for, is supported by a significant proportion of RMOs, both members and nonmembers.

We have certainly maintained membership numbers over the 2017 year. The increase in Trainee Intern (TI) membership has helped first-year membership numbers early on. TI membership drives at two distinct and coordinated dates during the year helps us capture this mobile group of RMOs-to-be, ensuring they are as informed and supported as they can be on day 1 of their life as a doctor.

Trainee Interns

The TI year is an incredibly important time. It's the last opportunity medical students have to become competent in the skills required as a first-year house officer. Of course, there are many skills you learn along the way once you become an RMO. However, we all know that feeling the first time your pager goes off (and often the second and third in short succession!) and you realise – you're it, you are the doctor on the end of the line, making that decision, performing that procedure, charting that medication. Triage is a very important skill to have as a house officer, and one that is not learned easily by observation.

Time is not something that is gifted to us. Not only are we making these decisions ourselves for the first time, but we are doing so under the pressure of time, distractions, and sometimes uncertainty. Yes, we have the support of our registrar or SMO; however, they are not always immediately available and are often under pressures with their own workloads. Supporting TIs in their final few months, giving them tips about the important things to know and practice before their first day at work (clinical and non-clinical), and some common MECA protections (cross cover and leave rights, for example) are all important things we can do to help our next first-year house officers be as work-ready as possible.

HOTTI

An initiative we are helping to further develop is the HOTTI course (House Officers Teaching Training Interns). I remember two points of my orientation – one was trying not to fall asleep at IT training in a warm room after lunch, and the other was when two first-year house officers spoke to us for a couple of hours about what you "need to know" as a first-year at Whangarei Hospital. Honestly, the five-day orientation could have been condensed to two, one day of the orientation "have to dos" and the other run by house officers themselves. That would have been a much more efficient use of time, and resulted in significantly better-prepared first-year house officers.

A lot of RMOs can relate to this scenario, which has resulted in the support for the HOTTI course to become an important part of the TI to house officer transition period. We have not forgotten about the other transitions we face during our working lives – house officer to registrar and registrar to SMO – and work to support these transitions is on the radar.

The MECA

We settled our hard-fought MECA. With the DHBs continual preference for shorter settlement periods, we find ourselves in bargaining more years than not. At least, that has been our experience in the last five years. Our MECA bargaining was at the forefront of our minds as we welcomed in 2017, having had one strike already and another planned for early in the year.

The sticking point for this round of bargaining was Safer Hours. Who would have thought a prime health and safety clause would be the seemingly non-negotiable claim? The DHBs never fail to surprise us. With a large amount of support from colleagues and the New Zealand public, and the powerful united voice of RMOs, the DHBs finally have given health and safety some priority,

agreeing to introduce safer hours into our most fatiguing rosters in New Zealand.

Safer hours

This has been a momentous occasion for RMOs in New Zealand, and, in the words of Julie Patterson, gives us "some of the best working conditions [for RMOs] in the world". This is something we should be proud of, and aspiring to. We are far from perfect, but any improvement in safety for both our patients and ourselves should be celebrated.

There are some challenges that we need to overcome with safer hours; two important ones being ensuring our training is minimally affected and maintaining team structure as much as possible. As new rosters are rolled out, attention is directed towards minimal disruption to these areas, becoming creative with options, and sometimes requiring change from our non-RMO colleagues. However, at the end of the day this clause is about reducing our fatigue risk first and foremost. Unfortunately when the risk is so high, nobody is immune to the effects of fatigue. While it would be nice to have everything else in place at the outset, the reality is some details will be a work in progress, and we must not forego safety while waiting for these. But guess what we will have? Safer rosters. Safer doctors. Safer patients. It's a step in the right direction.

One of the difficulties the DHBs had with this agreement was the idea that they would be paying us for days off. Clause 8.1.2 of our MECA essentially gives us our penal rates, although on paper it can be interpreted as paying for days we are not physically at work. This brings us to the deduction salary model introduced to get safer hours "over the line", so to speak. It's not a long-term solution, but it helped the DHBs feel more comfortable providing safer rosters. Yes, RMOs essentially agreed to pay for safer rosters: we do hold our own and our patients' safety as paramount.

Remuneration

Over 2017 the DHBs wanted to work on a new remuneration model. "Again?" I hear those of you that have been around for a few bargaining rounds ask.

This year we did get a little further with this review, in that we actually met with representatives of the DHBs to work through options. However, our optimism that this year could see the DHBs come to the table with a fair offer quickly evaporated. Their desire was for a more transparent, less complex and non-averaged system, although they didn't want the same hourly-based systems other health workers have (maybe because it would highlight how low our hourly rate is).

Essentially they appeared to want to take away 8.1.2, with little interest in fairly replacing the penal loadings it contains. Unfortunately, despite a huge amount of effort on our behalf trying to devise a cost-neutral model, the DHB representatives did not share this enthusiasm, and we will likely see this issue brought to the bargaining table for the umpteenth time in 2018.

On the other hand, rosters are being completed and having attention given to them by most DHBs. What was clear,

however, was that where RMOs either initiated, or were closely involved in, the writing and implementation process, the faster the rosters were finalised and introduced. This requires commitment by the DHBs to provide resources to assist.

It was disappointing, though not surprising, to see the Auckland region DHBs so far behind the rest of the country in terms of implementation. RMOs cannot do all of this work alone; we need the support of the DHBs to comply with our new safety clauses. We thank the DHBs that have worked with us to achieve these changes in a timely fashion, and hope that those yet to complete this work are not far behind.

Relief review

The relief review was also carried out this year. The initial review found that not one single DHB was providing adequate relief cover for all of their RMO rosters. It's no wonder the frequency of cross cover is so high. Having adequate relievers is important to allow leave entitlements to RMOs without further stressing an already stretched system. Access to annual leave is vital, and deprivation of this right leads to increased stress, fatigue, illness, inefficiency and unpredictable sick leave. Where services are already understaffed, this scenario can turn to disaster very quickly.

Relief runs are generally burdensome. Therefore as part of this review we looked at ways to make these relief positions more attractive. They are already paid two categories above, so money is not the issue. RMOs generally like runs to add value to their training (beyond the everyday on-the-job training), and most relief runs do not appear to be providing this. Rather, they are a service provision-only run. This is where Clinical Governance and Quality Improvement training can be incorporated.

We are currently working with some willing DHBs to create and trial these positions. A Clinical Governance/Quality Improvement training program is under construction, and RDA will continue to support and provide feedback on that process. Where this position has already been implemented the feedback is very positive.

MECA compliance

Compliance with the MECA requires ongoing monitoring.We know that this is one of the major issues for RMOs. It's all well and good having a MECA, but what happens when the DHBs fail to provide the agreed terms and conditions to protect us? Cross cover outside of ordinary hours is a prime example. This is a core health and safety clause: it is simply unsafe and inexcusable to have less than the already skeleton staff on after hours, let alone expect an RMO to cover the work of two busy doctors during that time. Despite knowing this, the DHBs still try.

To those coordinators we appear to simply be numbers on a board. Alerting the RDA to these incidents allows us to address this issue with the DHBs. Occasionally, this is enough for them to stop breaching our contract. In other cases, the breaching continues. The end-point of this scenario is legal action.

Everyone must remember: our MECA protects us. We don't have to keep saying yes, especially when our own or our

patient's safety is at risk. There is always somebody else who can help or take responsibility. By continuing to allow these breaches to occur unopposed, we are enabling the DHB's bad behaviour to continue.

We need to remember this: what the RDA doesn't know, it can't help with. It's up to us to report breaches, even if nothing can be done about them at the time. The power of numbers can never be underestimated.

And beyond

Other review processes that occurred this year were for different RMO units. Chronic patterns of poor access to leave, breaches of the MECA, inadequate access to medical education and RMO stress generally prompted these reviews. The importance of RMO units to be able to support RMO wellbeing and ongoing training, while continuing to run a well-staffed service, is often unrecognised as one of their roles. Some detailed proposals on how RMO units should function are being created. Depending on the final documents and following success, it would be good to have these functions generalisable as much as possible to all RMO units across the country.

Wellbeing

RMO wellbeing is always high on our agenda. We work in high-stress, high-stakes jobs. Our emotional wellbeing is challenged in multiple ways each day. Showing empathy is an important part of our jobs, as is keeping a clear mind in an emergency, decision making, multitasking, triaging, operating, teaching, delegating, counselling, and so on. All of these are affected by our physical, psychological and emotional wellbeing.

We spend our days caring for others, but unfortunately often do not extend this to ourselves. There can be multiple reasons for this – time, motivation, not giving our own health priority . . . whatever the reason, eventually this will catch up with us.

We know doctors have a proportionally higher level of depression and suicide than other professional groups. We must take care of ourselves if we are going to take care of our patients to the best of our abilities. Self-care is something we are trying to encourage all RMOs to place high on their priority list. We want to avoid the ambulance at the bottom of the cliff scenario. Eating well and regular exercise are often easier said than done; however, the positive effect of these two things on our physical and psychological health cannot be underestimated.

Mindfulness

Mindfulness can have a positive effect on our psychological health. Last year, NZRDA funded a one-year subscription to the mindfulness app "Headspace" for those RMOs who wanted to use this. Over 400 RMOs took this opportunity, and the feedback from this app has been very positive. We have also had discussions about funding psychologist appointments. Currently this is on an "as needed" basis, although regular (at least twice yearly) clinical supervision by a trained psychologist is something that I would encourage all RMOs to participate in.

EAP

DHBs provide the Employee Assistance Program (EAP). However, the uptake of EAP by RMOs is poor. We decided to do a survey on EAP use by RMOs, the barriers to its use, what was specifically offered by DHBs, and importantly the confidentiality around its use. Our survey found that 75% of RMOs did not know what EAP was. However, of the 25% who did, those who have used it had found it helpful. The barriers to its use appeared to be concerns about confidentiality, clarity around the skill level of those providing the service, and obviously knowing about the service in the first place! For those of you who don't know what EAP is, it's essentially a counselling service provided by the DHBs to assist employees who either want to self-refer or are requested to by the employer.

Most DHBs have information about EAP on their intranet, and RMOs can self-refer to this service. However, this is not the case in all DHBs, and some require the employee to meet with occupational health or HR first. This is obviously a significant barrier if an RMO is worried about confidentiality.

In addition, information is collected by DHBs about the demographics of those using the services. In a small DHB or department this also poses some confidentiality concerns. Lastly, there have been cases where confidential occupational health records have been divulged to the DHB without consent. This is a quick way for DHBs to stop the ongoing use of such a service by its employees. More work looking at EAP services will be done in the coming year to establish confidentiality and usefulness for RMOs. This is a free service, and if useful and confidential, is definitely worth promoting among our colleagues.

Bullying

We have embarrassingly high rates of bullying and harassment in the workplace. In 2015, NZRDA carried out a survey that identified concerning figures. 600 RMOs had experienced or witnessed sexual harassment, bullying or inappropriate behaviour against an RMO in DHB employment in the previous 2 years. International publicity regarding an Australian registrar's sexual harassment case had initially led to us investigating this further in NZ. We knew it was a problem, but didn't know the extent.

Not only do these negative professional interactions result in impaired mental health for those involved, they are also associated with poorer outcomes for our patients. High-stakes work and resource constraints are ever-present factors that will cause stress for doctors. Influencing the culture we work in can be the difference between this stress helping or hindering our work.

The Taskforce

Following these concerns, the "Professional Behaviours Taskforce" was born, and has been meeting regularly to work on reducing what we now term "unprofessional behaviour" in our workplaces (specifically focusing on doctors). The taskforce is made up of representatives of various professional bodies including DHBs, Medical Colleges, MCNZ, MOH, Universities, NZRDA, ASMS, and NZMSA.

This taskforce has spent a large amount of time collecting and collating information. There is no use reinventing the wheel. One thing is clear: we do not want yet another policy. We want action. We need a clear plan of what will be done, when, and how we will assess its usefulness. It's about losing the fear of speaking out; it's about bystanders standing up; it's about fostering and promoting positive interactions; it's about professional accountability. We must work by the rule of "the standard you walk past is the standard you accept." Some DHBs are trialing programs to help introduce systems that support good behaviours, such as those run by The Cognitive Institute. Simplifying the feedback system, making it confidential and having the right people in the right places is a start.

Confidentiality

Fear of career retribution underlies so many incongruent behaviours from RMOs, not least of which is speaking out against unprofessional behaviour. The DHBs have agreed to remove confidential references from ACE to support more honest feedback and remove some of this career retribution fear. The Colleges are still in discussion regarding this, but from our point of view there is little, if any, benefit to RMOs of their references remaining confidential. If there is concern about an RMO, they should be made aware of this and be supported to make improvements well before their reference is written. We have some work to do when it comes to constructive feedback in medicine. Supporting doctors to do this well is another important part of training.

Accreditation

On the subject of Medical Colleges, loss of ongoing accreditation of training runs has been threatened or occured in five DHBs over ten different specialties in the last two years. The concerning factor is not only the number of runs this is happening to, but also that these warnings often came as a surprise to the DHBs. Even more worrisome was that the threats could usually have been predicted by those working/training on that run.

In some cases, concerns had been raised, but resulted in little effort from the employers to change the situation, allowing it to get so bad that accreditation of that run was either threatened or lost. Due to the alarming frequency of this pattern, we undertook to meet with representatives from the training colleges, MCNZ, HWNZ and the DHBs to strategise how we could prevent it getting to this point in the future. This meeting was a very productive, open and honest discussion, and raised multiple areas that could be worked on by all parties.

Bullying and harassment played a reasonably large role in this discussion also, as did the apparent unequal weighting currently given to college assessments regarding professional behaviour versus clinical skill. The general feeling was that these needed to be of equal value and importance – just one step in stopping the cycle of this destructive behaviour. Hopefully this meeting helped the parties to understand the challenges faced by each, and how they could help each other to overcome these.

Communication is a key element. As RMOs working and training on these runs, we often know, before anybody else, those runs where accreditation is threatened. Communication from us to the RDA, to our colleges, to our Directors of Training or Chief Medical Officers is vital if we are to make changes early, before they become a significant problem.

Prevocational training

Changes to prevocational training since 2014 have proven to be a bit of a trial, with more changes to come. NZRDA has been providing feedback regarding these changes along the way. As a general rule, we give pretty raw feedback that is not necessarily what the MCNZ wants to hear – but we feel they need to hear it.

We do appreciate their continuing engagement with us on these matters; small changes now can prevent these becoming large problems down the track. Previous experience also tells us that what looks good on paper does not always work in practice. We have advocated for recognition of prior learning, with e-port beginning in the TI year. E-port itself has received a lot of attention to try to make it more "user friendly" and less like a "tick box" exercise. Part of this has been advocating for an e-port app, allowing significantly better accessibility for RMOs.

The idea of Entrustable Professional Activities (EPAs) received a lot of attention. A great deal more work needs to be done around developing these; however, they do appear to be the way the Colleges will look to move in the future, so it would make sense for the MCNZ to consider these assessment models also. I won't go into EPAs now, except to say they are a more practical and rounded way to assess capabilities.

Multi-source feedback has also been brought to the table, and while the theory is good, how it is executed will be important for it to be useful and successful.

CBAs

Community-based attachments (CBAs) are another reasonably new element of prevocational training. These were introduced in 2016, with a gradual increase in the number of attachments, aiming to have adequate numbers on offer by 2020. At that point, all RMOs will have to have completed one CBA in their first two years of training. With this target getting closer, it looks like it will be a challenge for some DHBs to meet this. We will be watching for an acceleration of CBA numbers over the next two years.

We have been monitoring the progress of these attachments, ensuring they are adding value to RMOs' prevocational training experiences, as we don't want to miss our opportunity! The feedback from these runs has been positive overall, not only for those already planning a career in the community, but also those planning on staying in the hospital setting. Most CBAs are currently in general practice, with a few also in hospitals, A&E centres and community mental health. There have been some issues with supervision and after-hours work back in the hospital; however, we address these issues as they arise. Over time we hope these will be an infrequent occurrence only.

NZRDA has recommended that

afterhours work in the hospital be voluntary, with additional duty payments being offered as usual practice. We also recommend that DHBs who are failing to increase CBA placement numbers urgently do so to allow all of their house officers a chance to complete one over their two prevocational years from 2020.

GPEP

The GPEP1 contract with the RNZCGPs expired at the end of 2017. Bargaining was initiated and was still in progress at the end of the year. This year we will be trying to change the term so that bargaining can be undertaken and voted on by the group of GPEP1s that it will effect (previously this was the year moving on). Practice variability can be a challenge, and we encourage any GPEP1s who feel they are not being treated fairly by their practice to at least speak up towards the end of their run (if not earlier). As a minimum, we would want to ensure no other RMOs were placed in that practice until these issues were rectified.

NZRDA relationships

NZRDA has strong working relationships with multiple key stakeholders in health, including the Medical Council of New Zealand, the Council of Medical Colleges, Health Workforce New Zealand and the New Zealand Medical Students' Association. This results in RMOs being represented in most discussions occurring in health. These relationships have been key in supporting us to progress many of the issues discussed above – and more.

Maintaining these relationships is important. Consultation generally results in fewer unintended consequences for RMOs and the health system. Our relationship with the DHBs has been damaged many times in the past, building a level of frustration at times. We are always hopeful that one day we will have a high-trust relationship where we can work together to achieve the best outcomes outside of the bargaining table too.

Lastly . . .

I would like to take this opportunity to thank my fellow National Executive members for your reliable support over the last year. We were straight into it from day one with strike notices and media campaigns, and you gave your all to this to fight for what was right for our RMO workforce.

There have been many different focuses this year, and it's been a true team effort sharing these responsibilities. You are an inspiring team to work alongside. For those who are moving on, good luck in your new adventures. I hope we never lose your voice; your views are always welcome and appreciated.

For those of you staying, keep doing what you all do best, and continue to represent your colleagues and hold their interests close to your heart. I will sorely miss our three-monthly reviews; these were always very inspiring times, seeing what passion and determination could achieve. It's very reassuring leaving the exec in such capable hands.

To Deborah and the team at CNS, who's enduring support never waivers, thank you. You all hold so many different hats and I have no idea how you keep up with

everything. We keep you busy we know. We certainly couldn't do what we do without you.

Deborah, your dedication and passion for RMOs as doctors and as people shows clearly in your work and what you achieve for us. You are an irreplaceable asset, and tens of thousands of RMOs are better off because of the support you have given us along the way. I personally have learnt much about representation, professionalism and perseverance from you. And one day, when I have glasses, I'm definitely going to use them as an "I mean business" prop. In all seriousness, you are a truly amazing wāhine toa: thank you on behalf of us all.

Last but not least, to all of you here today – thank you. A union is only as strong as its membership. I would also like to take this opportunity, on behalf of all RDA members and RDA support staff, to thank those delegates who give their time and effort endlessly in order to improve life for all New Zealand RMOs, our patients, and the health system we work in. You are all amazing colleagues and it's humbling to work with you. I hope the delegate training days we have just enjoyed have re-energised those of you continuing in your roles and motivated those who are new.

As members of our union we all play a vital role in ensuring our collective voice is heard. It's a privilege to be part of a union that has such a vocal membership, a very strong collective voice, and functions in a truly united and representative way. Thank you to all RDA members for helping to achieve what we have done so far. With our ongoing support for one another we will continue to make progress for RMOs of today and those who will follow in our footsteps.

RDA
skill
knowledge
care

Ki te kotahi te kakaho ka whati,
Ki te kapuia e kore e whati.

Alone we can be broken.
Standing together, we are invincible.

Nga mihi nui ki a koutou

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New Zealand Resident Doctors' Association

President's Report

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