What does NZRDA (AKA “the Union”) do?

Not an unreasonable question from a new House Officer fresh out of medical school, or for that matter an overseas colleague, given so few countries in the world have their very own organisation solely representing the interests of Resident Doctors. To those who have been around a while, you probably take much of what NZRDA does for granted; we get used to the fact that it is “there” providing a form of herd immunity for all to shelter under. But as with herd immunity, there needs to be a baseline level of participation for this collective form of immunity to work. Should the level of membership (in this case) drop, the protection follows suit. DHBs start to believe they can get away with more stuff, even the bureaucrats in Wellington start to (again) believe that Resident Doctors are a commodity to be deployed at the discretion of the system, rather than individual doctors with a life and career of their own.

So the first thing NZRDA does is actively lobby and represent your interests at a political, national, regional and local level. We are the only organization solely dedicated to representing Resident Doctors in NZ and work with groups such as HWNZ and the Ministry of Health, MCNZ, Colleges and DHBs nationally, ensuring your interests are being considered and not subsumed by other forces.

We appreciate there are other “forces” at work, and they are not all bad, but balance is important if we are to avoid unintended consequences. As an example, it was not that long ago when “sending” an RMO to X was normal. We didn't get a choice and if that hospital needed a doctor, that need overrode the wishes of the doctor. Today “deployment” as it is known, is voluntary for Resident Doctors. It does not mean that the needs of “X” are not genuine but there is more to it than simply sending one of us. Why is the hospital not attractive for starters, and what of the needs of the doctor’s career path or family? Maybe if “X” provided accommodation for a family and paid the removal expenses…..?

But we are also sharing knowledge in these forums: what you do, how you work and train or how you could work and train, and what you want in your future are all important. Resident Doctors are well informed about the predicted future demands on health, and adapt accordingly. Assisting to provide information to you about options and removing the barriers to making choices is part of the work we do.

NZRDA is run by 13 elected representatives; all doctors, and all but one (Dr Deborah Powell our National Secretary) are working as RMOs. Assisting them are a network of regional, hospital and specialty reps that act as contact points and communicators to and from the membership as a whole. NZRDA provides training to all delegates, a responsibility that will inevitably increase in 2014 as the new occupational health and safety legislation kicks in. Our current drive on safer hours is a salient case in point here. We also support increased input through funding reps to attend conferences such as the RACS and RACPs conference on generalist training.

NZRDA is a point of contact for the media, with National Executive members in particular taking a lead role to articulate RMOs’ viewpoint in the public arena. Maintaining communication with a wide variety of stakeholders as well as members (future as in TI’s, current and past) is an every day occurrence. For members, providing information on what is happening that might affect you is important if you are to be sufficiently informed to give an opinion on what you want us to do.

More on the immediate day-to-day front, we work with your employers (DHBs, Ministry of Health and other Public Health Registrar employers, and RNZCGPs) to secure and improve terms and conditions of employment. NZRDA negotiates both the GP and DHB collective agreements for members. We also enforce these documents, ensuring that your rights are respected. Unfortunately, but this is a significant part of the work we do as the tension between the employers’ needs (largely driven by financial and, as a consequence, service delivery needs) and your rights often result in your rights coming off second best.

Not only ensuring the employer doesn’t cut your salary without foundation (a salary review as required by MECA), but facilitating access to annual leave, interpretation of sick
leave entitlements, facilitating better rostering, reimbursing costs of training and other expenses such as transfer and APC / BPaC costs are all day to day occurrences for the staff in the office.

But surely patient care is more important than getting paid more? Only to a point... this is again where balance comes in. When terms and conditions of employment are poor it impacts on the quality of work you can do, job satisfaction and also life outside of work. Amongst any group of professional employees some will inevitably start to look elsewhere resulting in recruitment and retention difficulties, and as the lack of doctors bites, patients and their access to sufficient quality care drops. General Practice is our primary concern in this regard at the moment as in 2014 we saw the lowest number of GPEP trainees being employed for 4 years; yet at a time where we all agree we need to increase the GP population. The problem – the salary offered in GPEP 1 is too low representing a $30,000 - $50,000 pay cut. Plans for improved integration of primary and secondary care are not going to get very far unless this poor cousin attitude towards GP is addressed.

You also have rights as an employee, and as a person to a life outside of work. To enjoy that you need time away from work not just every day but annual leave for recuperative breaks; and sick leave to ensure you don’t come to work and spread whatever infection you have acquired…. And you have a career you will wish to pursue. Working to secure access to quality training opportunities is a work in progress with training in private on the drawing board: costs of training is also a significant advantage we have over our Australian counterparts, where they must pay for everything on top of their student loans!

Down to the direct one on one individual level, we not only enforce contractual rights, but those of an employee to be treated fairly, with respect and without discrimination or bullying. These processes are called personal grievances.

NZRDA will and does take legal cases to ensure members’ rights in all these areas are respected. NZRDA also assists NZMPI with indemnity cases involving RMOs, putting the workplace environment into perspective, and supports RMOs undergoing HDC, MCNZ or coroners inquiries and the like.

So in summary, yes NZRDA is a Union with all the attendant responsibilities that brings with it, but we have a broader role as the representative organisation for Resident Doctors in NZ. The more input we get from you, the better we are able to do our job, and in turn your working lives and access to training is improved.

Annual Leave Guide

Over the holiday period NZRDA receives a number of annual leave queries from our RMOs. It is important for you to be aware of your rights in this area to ensure you get that well deserved break.

You are entitled to 30 days annual leave each year. The DHB must take all reasonable steps to ensure you get your entitlement and must respond (in writing) to your leave application within two weeks of receipt, either approving or declining your request. If leave is approved, it is important for you to have this confirmation in writing and remember, leave cannot be revoked after it is approved.

If leave has been declined the DHB must provide the reasons why. If you are not satisfied with their response, you may reply seeking more information about their decision. Some useful questions to ask are:

- How many others on the roster are taking leave at that time, and what type of leave?
- How many annual leave relievers are there assigned to provide cover on this run for how many RMOs (i.e. is there enough relief resource)?
- Has the DHB contacted locums to see if they are available at that time?

Contact NZRDA if you have further concerns about access to leave or whether sufficient resource is available to provide adequate cover.

When a public holiday falls during a period of annual leave you are entitled to that holiday and it cannot be debited against your leave entitlement. Furthermore, where you are on leave on the days immediately before or after a weekend you cannot be required to work on that weekend (you do not need to use your annual leave to not work). This applies to all leave except time in lieu of public holidays.

The DHB may require you to work on a public holiday to maintain essential services. If you do work on a public holiday you are entitled to a day in lieu (a TOIL day) and to be paid time and a half. Your TOIL days must be taken within 12 months of entitlement. These days can be taken with 14 days’ notice and while you must consider your employer’s view as to when is convenient; essentially they are at your discretion.

2014 National Executive Nominations

Don’t forget, nominations are currently being called for the 2014 National Executive of NZRDA. Any nomination form must be signed by the individual being nominated, proposer and seconder, all of whom must be NZRDA members, and reach the returning officer no later than 5.00pm on 21 February, 2014. These positions are to be filled as of the Annual General Meeting, scheduled to be held in Rotorua on March 22, 2014. For more information, or if you have lost the nomination form, please contact secretary@nzrda.org.nz.