RDA NEWS

SEPTEMBER 2016

A FEW MEETINGS WE HAVE ATTENDED RECENTLY...

- 16 June : with Waitemata DHB to discuss health, safety and wellbeing;
- 23 June : with North Shore Hospital to discuss the Gen Med roster;
- 27 June : with Hawkes Bay DHB to discuss the Paeds roster;
- 27 June : with Middlemore Hospital to discuss the Gen Med and Subspecs rosters;
- 27 June : with the Auckland Region DHBs Human Resource Managers;
- 5 July : with Southern DHB Management Team to discuss various RMO issues;
- 5 July : with RMOs at Invercargill Hospital;
- 7 July : with Canterbury DHB to discuss the Surgical Department;
- 8 July : with the Medical Council to discuss Pre-vocational Training;
- 11 July : with Health Workforce New Zealand to discuss funding;
- 14 July : with the Community Based Attachment Management Group;
- 18 July : NREG (National Resident Engagement Group);
- 20 July : with the employers - RDA Bargaining;
- 25 July : with Canterbury DHB to discuss future challenges;
- 26 July : with Auckland DHB to discuss engagement with health and safety.
- 27 July : Health Quality and Safety Commission Workshop (see below);
- 4 August : Bargaining Trends and Employment Law Update Seminar.

Health quality and safety commission workshop

The New Zealand Resident Doctors Association held a workshop on Clinical Leadership on the 28th of July 2016 in Wellington, the city of bad-hair-days. This 1 day development program was run by Health Quality and Safety New Zealand (HQSC) alongside Synergia (An Australian and New Zealand organisation which focuses on applying research, evaluation, policy development and service consultancy skills to complex issues in health and social sectors).

Around 50 RDA members and delegates were given the opportunity to think about their own leadership qualities, exchange pearls of wisdom with their colleagues and listen to experts.

The title of the conference was 'Developing clinical leadership for quality and safety'. The module was broken down into 3 parts;

1. What makes us a great clinical leader?
2. Using data to support improvement
3. Leading change within a complex system

To welcome us we had a brief introduction from Liz Price from the HQSC, and also met our two presenters for the day Peter Carswell (from Synergia) and Catherine Gerard (from HQSC). Peter took us through what makes a good clinical leader and taught us about complex versus complicated systems.

Peter's sections of the workshop concentrated on getting us to think about ourselves as leaders. He stressed that leaders are not born, but rather that leadership is learned. We need to be thinking about how we can effectively lead change, and how to develop a network of people around us to achieve our goals. He framed the talk around quality improvement in medicine, using examples of failures of clinical leadership such as the Stafford hospital scandal in the UK.

One of the most interesting parts of the talk was Peter explaining the difference between a complicated and complex system - using his definitions of the two to explain why applying a 'one size fits all' solution to health care often ends in disaster. Saying that one can think of a complicated system like a bicycle, while a complex system is like a frog. A bicycle can be taken apart and put back together, and you will still have a functioning bicycle. A frog can be taken apart and then put back together... but you no longer have a functioning frog. A complex system takes into account the relationship between all the moving parts.

An example might be the 6 hour ED targets. If you simply tell ED to remove patients from ED within 6 hours or face consequence, they WILL move patients. But if there is not increased resourcing of the accepting wards of these patients, do we really improve patient care? Or do we just meet a standard on paper? This inspired much heated debate, much to the delight of Peter (he commented we were the most vocal bunch he had ever taken in a course, ka pai RMOs!).

Meanwhile Catherine gave us some much needed insight and teaching on interpreting data. The attendees enjoyed the practical spin on data analysis; applying this to clinical decisions and patient care.

The overall opinion was attendees felt they had a better understanding of leadership qualities, and had gained a good foundation to think more about the ways they will continue to better themselves as leaders in medicine. The RMOs also liked how the talks were tailored to practical subjects, with examples we can relate to. A huge thanks to the RDA for organising, and RDA Education Trust for funding the workshop. We look forward to more opportunities for young leaders in medicine to come together and grow our skills.

Sick leave – your entitlements (and duties…)

One area we sometimes get involved in is the allegation that an employee has taken sick leave when not sick. The employer has a reasonable right to satisfy themselves that an employee on sick leave is actually sick; a right that extends beyond simply providing a sickness certificate if the employer has reasonable grounds to believe the certificate is invalid. Too full of the cold to work, but fine to go shopping (and run into the employer!) is an example where sickness certificates won't work.

Which takes us to why we have sick leave in the first place – because we always have? Not so: in days past employers argued they would only pay for work – no work no pay. It wasn't their fault an employee, let alone an employee's child, fell sick. Sick leave was introduced by employers to act as an insurance type arrangement: effectively managing staff illness as a risk to the business with a maximum defined cost.

We recently talked to one member who wanted to "use up" their sick leave entitlement as they had accumulated some days over the preceding year. Thinking about it however, to do this they would have to know when they are going to be sick and only so sick as to use up that set amount of leave.

They were also under the impression that sick leave was akin to an entitlement, like annual leave, which it is not. It is there in the event you are sick, with a defined maximum "risk" to the employer, not if you simply want to use it.

Whilst on the topic we should mention that the employer does not have the right to know what illness you are suffering from (unless directly related to the work you do – another entirely different topic!) and the reason you are taking sick leave does impact what you can do when on sick leave e.g. if on leave for a broken leg, you can still go to the movies! Suffice it to say the duty of honesty an employee owes an employer includes the duty to be honest about taking sick leave.

Where do i find the relevant provisions in my contract?

For those of you employed by a DHB, MECA Clause 21.0 (pages 31 and 32) and for those working for the RNZCGP SECA Clause 11.4 (page 11).

How much sick leave am I entitled to?

The DHB MECA entitlement is dependent on the length of time you have been working as follows:-

Year 1 – 4 you are entitled to 30 working days of sick leave a year. Once you reach 4 years of service your sick leave begins to accrue, you accrue 30 working days in year 4 and 9 working days per year thereafter.

The RNZCGP SECA entitles you to up to 15 days during the term of employment (pro rata for part time employees).

What am I paid when on sick leave?

You are entitled to your normal hourly rate.

Can I take sick leave to care for others?

Under the DHB MECA you can apply for leave on pay which is deducted from you sick leave to stay at home and care for an unwell child or member of the household.

Under the RNZCGP SECA you can take sick leave to care for a spouse, partner or a person who depends on you.

You may be required to provide a medical certificate or other evidence of illness of the person in question.

Sick leave cannot be used in connection with the birth of your child, for this purpose parental leave must be taken.

Am I responsible for finding cover if I am sick?

No, you are not! If you are off on sick leave it is the employer's responsibility to organise cover for you. You are not required to assist with sourcing cover for your own leave and you do not need to hold yourself available whilst on sick leave. Rest up, get healthy!

As always, if you want to know more please contact us. Even if about a sensitive matter, best get advice first!

Meet your delegate: Alistair Papali'i-Curtin

Hi, I'm Dr Alistair Papali'i-Curtin and I am one of the RDA delegates at Dunedin hospital. I am PGY6 and in my second year on the ophthalmology training scheme.

I became a member of the RDA when I started working as a PGY1 House Surgeon at Middlemore hospital. Since then I have worked in Whangarei, Wellington and now chilly Dunedin.

As a member I have benefitted each year from the RDA's sage advice on topics such as annual leave, education costs and cross cover. I have really appreciated the RDA's responsiveness to emails and their availability to talk about an issue. After many years of benefiting from their service, I became an RDA delegate this year to do my part to support RMOs locally and those within subspecialty areas.

If you aren't an RDA member - sign up! Our union can only continue to represent us effectively if we engage as a collective. Another key aspect I really appreciate about the RDA is its ability to quickly canvas the opinion of members on important topics via Survey Monkey. The response rate of RMOs using this method has been extremely high and rapid. Importantly, the union listens to its members and responds accordingly. Sadly, however, if you are not a member your voice is unlikely to be heard. Sign up on the RDA website and get to know your local RDA delegates – we are here to help.