Secretariat Report 2018

NEW ZEALAND RESIDENT DOCTORS' ASSOCIATION

Dr Deborah Powell

Welcome to the 2018 Secretariat Report.

MEMBERSHIP

Our membership has remained stable throughout 2018 at 3300-3400 with a burst of additional members joining ahead of strike action late in the year.

With the advent of SToNZ we could have expected a reduction in overall membership, however this did not occur. We believe the reasons are as follows:

1. The original SToNZ members were not NZRDA members and with one exception had never been members of NZRDA. At the time of initiation, SToNZ membership (NMDHB excluded as they at time of writing have refused to respond to our OIA request) was 41, as follows:

DHB	No. of SToNZ members	DHB	No. of SToNZ members
NDHB	0	**MCDHB**	1
ADHB	5	**Whanganui**	0
WDHB	3	**CCDHB**	2
CMDHB	3	**HVDHB**	2
BOPDHB	3	**Wairarapa**	0
Waikato	4	**NMDHB**	-
Lakes	0	**WCDHB**	0
Taranaki	2	**CDHB**	10
HBDHB	2	**SCDHB**	0
Tairawhiti	0	**SDHB**	4

2. Given the timing of the SToNZ settlement at changeover, a number of NZRDA members who were qualifying at the November/December changeover to become fellows, joined SToNZ to get the lump sum payment. These people did not resign from NZRDA any earlier than they would otherwise have done as they graduated into SMOhood. Whilst they may have paid an annual subscription to SToNZ who appeared to have difficulty setting up fortnightly or monthly payment systems, they will equally no longer be SToNZ members (or eligible for membership) as they are SMOs. Whether SToNZ has continued to record them as members is unknown. NZRDA has not. Overall for NZRDA, the balance between RMOs reaching fellowship and TIs commencing employment as RMOs saw no change from previous years.

3. Some basic surgical trainees have taken out joint membership i.e. are members of both SToNZ and NZRDA. This group is in an awful position – believing, and in some instances, we are informed they are being told to join SToNZ to improve their chances to gaining entry into the surgical training programme. As they have retained NZRDA membership, this suggests their confidence in SToNZ to represent them may be limited. This would not be an unreasonable assessment given this particular group of RMOs will suffer under the SToNZ agreement through for instance losing the automatic right to costs of training, limiting the number of attempts at exams and ultimately the loss of the mutual provision requiring the employer to provide what is needed to participate in the training programme. This is on top of the generic deficiencies in this MECA, such as a reduction of sick leave.

CNS

I have held the position of National Secretary on the NZRDA National Executive for the past 30 years and until more recently, I have also been the owner of CNS and as a result employer of the staff it employs. CNS is the company which delivers industrial services for NZRDA. My position on the National Executive is a non-voting position; my role to provide the connection between accounting to the Executive for the services it wishes to have delivered and for the quality of those services.

This structure was set up when NZRDA (then NZRMOA) first gained permission (as was required back then) to represent RMOs. The turnover of delegates and importantly executive members, as well as a lack of skill sets needed to employ and manage staff, was the primary reason to form this contractual service delivery relationship. All responsibility and risk of the employment relationship rests with CNS: in 2018, CNS employed 18 staff including; 3 senior advocates, 4 advocates, 4 associate advocates, communications, financial and accounting, membership and clerical staff.

The structure also assisted the executive to manage and monitor an ongoing workplan with quarterly review, as well as the finances of the Association, and provided a repository for all matters related past and present to the Association, a historical record. The contract has always been set on membership numbers but that being less than either the full number of members and the full membership fee paid by each one. Discretionary expenditure outside the core contract has always remained the responsibility of the Executive. This regime has allowed the NZRDA to have guaranteed service delivered to its members for a set price that was always less than income, through which NZRDA has also been able to build a sound financial base.

At the end of my current term as National Secretary in March 2020, I will not be making myself available for re-election. I am not “going anywhere” however I do believe it is time for a new guard to come through. We have been actively succession planning and believe that in order

to manage an orderly transition, giving ample notice and the opportunity for the Association to think about the next 30 years is appropriate. As 2019 progresses, there will no doubt be further discussion on this issue.

STOnZ

2018 has been marred by the prolonged and acrimonious bargaining for our National DHB MECA and associated advent of a second union representing resident doctors. STOnZ was created by advanced surgical trainees who had never been members of NZRDA, despite enjoying the products of the work that we have done. However, when it came to Schedule 10 and safer hours of work, these individuals perceived a threat to their training spurring the creation of an alternative.

The evidence in support of safer hours is unequivocal; even STOnZ agreed the 7 days of nights were unsafe. Their particular focus was on the reduction from 12 days in a row to 10 days with 4 days off in that fortnight. STOnZ members saw this as a loss of training time to which they objected.

There was no evidence however that training would be affected. The Trainees' own survey from the 5 years to 2015 recorded that General Surgical respondents in New Zealand work the longest hours on average at 63 hours per week (excluding on call) compared with Australia. Worryingly perhaps, that same survey recorded a 1:5 frequency of 24 on call with only 3-4 hours uninterrupted sleep per night, which the evidence on fatigue would support, is unsafe.

Furthermore, any increase in the length of a training programme has to be notified to MCNZ: to date no college has informed MCNZ that they are reviewing the length of the programme let alone as a result of hours worked or numbers of cases achieved being insufficient.

Whilst we appreciate the fear factor, we have always attempted to operate on the basis of evidence and with regard to safety, both the evidence was clear and the priority over training likewise. The SToNZ members had different priorities.

NZRDA did attempt to engage with SToNZ prior to the formation of their union. In mid-2017, we replied to an inquiry from an advanced orthopaedic registrar acknowledging the mutual concern regarding fatigue, but questioning the implication made in their letter that this affects orthopaedic trainees less than others.

On the issue of training, we reiterated NZRDA's commitment to quality training for all our members and pointed to a number of many mechanisms contained in our MECA to protect and enhance such. We also noted that threats to training have not (ever) come from safer hours: they have come from poor management or a lack of priority given by management to this part of our lives. The loss of accreditation that has plagued us in recent (pre safer hours) times being case in point: something that saw NZRDA call a meeting of all interested parties to seek to resolve.

We also noted that our working lives are complex and acknowledged the many balances that have to be managed, but that in this context, fatigue and its negative impacts will have more weight than length of training time. This is simply because the risks of fatigue are serious and it would be unconscionable for us to put our training ahead of patient safety, if not our own wellbeing.

Nonetheless, we expressed a desire to understand better the problem(s) as they saw them and to address those problems. We finished by reassuring them that they would have NZRDA's support in addressing such issues.

By mid-2018 when we next heard from SToNZ, they had already formed a union, changing both the dynamics and opportunities for engagement. What SToNZ probably didn't appreciate when they formed their union and initiated for bargaining was the use the DHBs would make of their existence. Through settling a markedly inferior collective agreement and then running NZRDA's bargaining out of time and with a view to leave this inferior contract as the only one in existence was a clear DHB plan to us at least. In their own minds, we have no doubt the employers believed this would force our members onto the SToNZ contract, however with

changes in legislation still pending and the final form of the Act unsettled at that time, whether the latter occurs is still to be seen and will be the subject of the 2019 report.

Also, of note is that in 2017, a (now) SToNZ registrar opened up the idea of a separate collective agreement for surgical registrars. In reply to that option, we invited further discussion but warned of the likely risk they would invite, including facing clawbacks and trade-offs in return for a desire for "training". With the benefit of hindsight, we could not have hit the nail more firmly on the head, although at the time of settlement, I doubt SToNZ realised how much they had given up in their MECA. Their single-minded focus on schedule 10 appears to have trumped all else, so much so that a myriad of clauses was amended to the detriment of RMOs terms and conditions overall. Without going into all the details, the SToNZ MECA, in addition to removing Schedule 10, also means:

- SToNZ members can work more than 2 long days in 7 as long as those days are no longer than 12 hours.
- Despite the earlier mutual acknowledgement of how dangerous 7 days of nights are, the SToNZ MECA reintroduces this, as well as 4 consecutive night shifts of up to 12 hours each. 3 consecutive night shifts will only have 2 sleep recovery days.
- Participation in a training programme as a condition of employment (thereby requiring employers to provide RMOs need to participate in that programme) was replaced with a duty on the employee to meet the requirements of the programme with no equal responsibility on the employer to provide the necessary access to clinical material, support etc.
- Compensation for the lost salary as a result of the deletion of our penal rate (8.1.2) saw all salaries categories shifted up one. But this was not applied to the ED and ICU salary scales. It also removes future protection around shift work and unsocial hours compensation.
- Run reviews to determine the correct salary are effectively controlled by the employer and only open for review every 6 months.
- Protections around first years working in ED and ICU were reduced and first years only protected from nights for 3 months.
- Any rotation between any hospital or DHB are permissible – no agreement is effectively required because inclusion of a rotation in a letter of offer will constitute agreement.

- There are no provisions for dental house officers or registrars.
- Protected Teaching Time has been reduced to 2 hours for all house officers.
- Medical Education Leave was also reduced to 5 days per annum and a one off 15 additional days for all house officers and registrars who are not in a vocational training programme. Even then, vocational training registrars are only entitled to 12 weeks; more is not available if a dual trainee. The 2 weeks for a diploma remain subject to support from a CD or appropriate clinical lead.
- Costs of training have been restricted to registrars in a vocational training programme except that other registrars will be able to access $2000 PA (to a max of $6000) subject to 12 months previous employment and DHB policy. House officers and non-training programme registrars will be entitled to further costs when supported by their clinical lead.
- Parental leave is no longer applicable to both males and females equally but restricted to the "primary caregiver". The other partner has 2 weeks paid leave.
- Relievers notification periods have been reduced.
- Call backs are a minimum 3 hours as opposed to our 4 hours.
- Sick leave provisions have been reduced.
- The duty on the employee to ensure they manage their own fatigue by (ironically maybe) accessing annual leave and leisure time activities, is specifically provided for in clause 19.4. and leave abutting weekends only applies to annual leave unless the DHB agrees.

1/3rd disagreement to changes to run descriptions amongst a number of other changes were to be subsequently heralded by DHBs as so reasonably accepted by the minority union, and therefore something the majority union should of course accept. The blatant use of SToNZ to undermine the activities of an independent and bone fide union did not go unnoticed. In August, an unrelated union Facebook page expressed the view that unions such as SToNZ that settle *"weak contracts that benefit the few at the expense of the many… are encouraged by employers for obvious reasons."* Further commentary amongst the wider union movement continued to be concerned at the undermining impact on a legitimate union such as NZRDA and especially one that has taken a stand of health and safety.

This debate escalated when it became known that the PSA was assisting SToNZ to both set up as a union but also in bargaining. Not only did many in the wider union movement decry the PSA's actions, those within the PSA also did. In September, PSA members wrote to their National Secretary as follows:

"We the undersigned, representing ourselves as individual members of the PSA, are gravely concerned about the apparent support given by the Public Service Association to the newly formed Specialty Trainees of New Zealand (SToNZ).

We believe the formation of SToNZ is a transparent and indefensible move to undermine our brothers and sisters in the Resident Doctors Association (RDA), who in 2016 and 2017 successfully led an inspiring and just struggle for safer hours of work in our hospitals.

This series of strikes and public demonstrations by young doctors received overwhelming public support, including from PSA members.

While RDA members went without pay in order to lead one of the most significant industrial disputes under the previous National government, those represented by SToNZ instead crossed picket lines, and have admitted to doing so on public radio.

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The rationale for the formation of SToNZ boils down to this: a small group of workers do not want to be inconvenienced in any minor way, even if that inconvenience is to the betterment of the vast majority and sets a precedent for improved conditions of work.

The vast majority of junior doctors support the RDA and support the safe staffing measures won in the 2016/2017 strikes. Safe staffing can only be successfully implemented over time if it applies across the board.

The formation of an organisation which threatens advances made for safe staffing in any sector is dangerous, short-sighted, and damaging to the union movement as a whole.

For the sake of the PSA's reputation as a legitimate organisation for workers, for the sake of solidarity, and for the sake of safe staffing levels for all, we urge the Executive Board to withdraw its support for SToNZ. We do not support our union providing contract services to an organisation which seeks to undermine the collective agreement of another trade union."

Our National Executive was grateful for the support the wider union movement gave during those trying days so much so that an inquiry was made as to whether affiliation with the Council of Trade Unions was appropriate.

This venture hit the rocks however when Richard Wagstaff, President of the CTU and ex national secretary of the PSA, refused to support NZRDA in the struggle that by then we had on our hands. This was exacerbated by the leaking of an email from a (current) National Secretary of the PSA that was hugely critical of NZRDA and CNS as its service provider. The email was highly emotive, factually incorrect and supported the PSAs role in assisting SToNZ.

Nonetheless by early 2019, lines had been drawn and the CTU affiliates council voted 9 to 4 to adopt the following resolution:

"That the CTU expresses concern in the strongest possible terms to the DHBs for the collective bargaining strategy adopted in their MECA negotiations with the RDA which includes (a) the undermining of a union that is in bargaining with the potential effect of "union busting" and (b) taking advantage of the vulnerability of Resident Doctors due to their dependence on changing DHB employment for their training. Further the CTU urges the Government to urgently require DHBs to discontinue this strategy forthwith …"

In favour of the motion were NZNO and ASMS and against the PSA. There were 2 abstentions. What more may come of this we will have to wait and see.

After 30 years as National Secretary, my personal grief at seeing a few risk terms and conditions so many RMOs have fought for over the years was surpassed by concern for current and future RMOs. The life members shared my initial concerns and wrote comparing the SToNZ developing situation to that of vaccination noting that with a lack of RMO unity comes a lack of herd immunity and going on to say:

The above medical example is an illustration of how easy it is for previously hard-won gains to disappear if collective action, cohesion and lessons of the past are forgotten. RMO working conditions – which have improved steadily and necessarily over the past 30 years – are a vaccine against fatigue and unsafe work practices. Back in the dark ages of the 1980s, RMOs often worked more than 100 hours a week as there were no limits on hours. Doctors suffered. Their families suffered. Patient care suffered. Over time, most doctors have come to realise that the approach of "work till you drop" is simply not acceptable if we are to deliver safe care, participate effectively in training, and sustain our own personal wellbeing. Society's expectations of the quality of care they receive has rightfully increased, and fatigued doctors delivering substandard care cannot be tolerated or condoned for any reason, including the excuse that training requires doctors to work demonstrably unsafe rosters.

… Health services are under ever increasing pressure like never before to provide more complex care for ageing and multimorbid populations with relatively fewer resources. In this environment all health care workers, including RMOs, are at great risk of bearing the brunt of these pressures and suffering from regressions to working conditions not seen for many years – and indeed well beyond the memory of most RMOs working today.

Individual RMOs or small groups of RMOs are vulnerable to inevitable (and understandable) pressures from our hospitals, our colleagues and our patients. We are vulnerable to our own desire to always say yes and not disappoint those relying on us, even if doing so carries short- and long-term risks. We are vulnerable to misperceptions that time not spent in service is time not learning and not training

…The RDA provides that collective medical culture. It sees the bigger picture. It protects RMOs through their most vulnerable years, when doctors face myriad pressures to work and train and still have some sort of life. The RDA has done so for nearly 30 years and is more vital now – and more an intrinsic part of our health sector – than ever before. And yet, like those who won't vaccinate, the good work of many hard-working colleagues over many years can be still undone by the actions or inactions of the selfish, naïve and solipsistic. Personal short-term exigencies, misinformation and flat-out inaccurate information is never the way to better health and a better system…"

The life members raise many important points, one of which is the role NZRDA has taken to advance and protect members when they have been unable to do so themselves. Over the last 30 years there has been many a time I have defended RMOs' rights when they have felt unable to stand up and do so, even to the point of having RMOs contradict me in meetings despite privately in advance asking we "not give up". And not only I but other advocates, national exec members and delegates; and we have done so willingly, we do understand what that perceived threat feels like. But like our work on bullying and inappropriate behaviour, maybe it is time to stand up; maybe it has to be? We can provide some herd immunity if we all say enough is enough, but if we don't make this the last generation to be so affected, unless we are prepared to say this stops here, with us, how much longer is the DHBs current claim that RMOs are not vulnerable, that it is all just the RDA throwing its weight around will we be able to withstand.

The publication on social media of the story of Dr Kokoda, an Australian aspiring surgical trainee, put matters very firmly in perspective for me. Knowing many of the SToNZ members retained NZRDA membership, knowing (see below) of the limited real impact the work to address bullying and inappropriate behaviour has had, the pervasiveness of the fear of career retribution and the control the old boy network has to this day over RMOs, made the entire threat to the safeguards contained in our MECA front and center. Surely core business for any union is to protect its weakest, its most vulnerable, and maybe even when those said same individuals will do "whatever" it takes including undermining themselves and their colleagues.

The basic surgical trainees who responded in a way they perceive they have to in order to progress in their careers, are now being financially, psychologically and physiologically disadvantaged by this situation. Unfortunately, the college appears limited in their ability to take these concerns more seriously, despite their work to address inappropriate behaviour. In reply to our raising concerns, they simply stated "A junior doctor's decision to be a member of a particular union, or not, will not affect entry into training programmes. I intend to comment on this in our next newsletter."

BULLYING, INAPPROPRIATE BEHAVIOUR AND SEXUAL HARASSMENT

Which brings us to this issue. In 2015, NZRDA successfully brought all stakeholders together to acknowledge and commence work to change the environment within which we work, including ASMS, CMC, MCNZ, RACS, NZMA, Medical Schools, NZMSA, DHBs (CMOs and GMsHR) and the Ministry of Health. Our agreed purpose is to:

- ***Promote*** a focus on positive behaviours and cultures and develop capabilities to support this (e.g., skills training in appraisal process, provision of constructive feedback and reflective action);
- Take ***responsibility*** within our organisations and the wider groups of people we represent to acknowledge that there are existing issues with bullying and harassment[i], promote the safe raising of issues and processes to address the issues;
- ***Identify*** and support the ***coordination*** of activities to improve cultures and behaviours; and
- ***Identify*** opportunities and/or gaps.

We agreed on 4 key actions that were required:

1. Leadership starts at the top, but equally all leaders must be courageous and demonstrate personal competence in this area, step up to be role models and support change. Active choices and actions are also required from our leaders including in the:
    - Selection of clinical leaders and managers; and
    - Development of capacity to drive a positive culture in both clinical and human resource leadership and management; and

- Skills training for leaders, including in appraisal processes, provision of constructive feedback and in reflective action.
- Active use of the tools available to leaders to reinforce appropriate behaviour including multi-source feedback, professional development, and performance appraisal and development.
- Incorporation of principles and key performance indicators, that promote and mandate appropriate behaviour, into accreditation processes.

2. Empowerment of bystanders – such that bystanders 'stand up, don't stand by'.

3. Providing a secure and safe environment to enable affected individuals to raise concerns, including ensuring retribution or negative career consequences do not arise as a result of raising an issue.

4. In addressing concerns that have been raised, the initial focus should be on the affected individuals, the issue at hand, and on resolution, whilst also recognising when formal disciplinary processes will be necessary.

NZRDA also was successful at getting the stakeholders to appreciate the impact confidential references and referees have in underpinning the fear of career retribution and secured a commitment to remove this from our appointment system.

But by mid-2018, matters had stalled. We were all asked to provide a report on what we had done and believed still had to be done at that time: to the best of our knowledge NZRDA was the only respondent (the taskforce has now not met since this time).

We noted that NZRDA:

- First raised the issue for NZ attention following the Australian expose, as a result of a NZ wide survey of inappropriate behaviour being experienced in NZ workplaces by RMOs.
- Provided information on what bullying is, and importantly what it is not as well as circulating advice on forms of assistance and where to get help.

- Maintained communication regarding activity with NBAG, the all-of-union-DHB bipartite forum.
- Co-sponsored with ASMS a bipartite visit to Melbourne to examine the Vanderbilt cultural change programme and its operation at Royal Melbourne Hospital. NZRDA continues to support DHBs investing in cultural change programmes including actively contributing to senior management steering groups.
- Continues to support RMOs who are the victims of bullying, raising cases with employers both on behalf on individuals or collectively through NZRDA's own auspices. In the latter instances, it is NZRDA's view that, given we are a credible organisation, such a complaint must be investigated by a reasonable employer.
- When alerted to potential inappropriate behaviour by one of our own members, NZRDA has accepted responsibility to directly approach and "have a chat" as the first line of informal intervention. NZRDA also has deployed resources to provide counselling assistance to those in need.
- Lobbied for the abolition of confidential references and referees as a critical source of the belief that standing up will harm career prospects.
- Supported the building of competence within the profession of the skills needed to have "difficult conversations", give and receive constructive criticism and assessment.

A lot of work, yet in our assessment of where to from here we had to note that the fear of career retribution is still stifling RMOs from standing up or bystanders from taking action. Whilst change has occurred, we believe we have been assisted in some part by the benefits of a negative public reaction to the highly publicised impacts of inappropriate behaviour. Those that recognised a need to improve readily accepted the assistance provided (early adopters) and some were simply prepared to go along with what was on offer. We still have too many colleagues however who have not fundamentally changed, and I include management to the most senior level in this category.

The DHBs continued refusal to accept the impact inadequate resources have on workplace behaviours and the contribution senior management (by their own behaviours) have on this issue is disappointing. The same can be said for other senior leaders in health. The current MECA dispute highlights just how blind DHB leaders are to the impact their own behaviours have on the RMO workforce.

We also continue to experience issues that come to light informally (e.g. a manager being told of some events or occurrences) being frustrated by process, often at departmental or service level. "A complaint has to be put in writing" is a common one used to dissuade people from coming forward or as an excuse for managers to avoid the first conversation.

What more do we need to do?

We suggest we need to implement a 'teach the teachers programme' including the topic of" having difficult conversations" to all levels of the medical profession. This should be a progressive learning programme starting at the TI level, through to house officers, registrars and SMOs.

All levels of the profession teach; we should not wait until the doctor is an SMO, assume they know because they are a doctor, or impose the skill sets by "dump learning". In our view, the programme will improve performance in the giving and receiving of constructive criticism and feedback, as well as competence at challenging conversations and lead cultural change from the bottom up.

A collaborative approach incorporating the skills and resources already available within our DHBs, universities and colleges should be made available in a nationally consistent framework that would include a "teacher's self-directed passport" recording doctor's competence at each stage of their career. This will be transportable between workplaces. Resources for both those providing the course and those undertaking it (time and costs) should not be borne by the doctor but should form part of CPD.

We also need to actually see the abolition of confidential references and referees for all RMO positions: we all agree it should happen – *so why has it not?*

And, we need definitive protection for those standing up from negative consequences including any risk to career. This will require an agreement on how to manage the tension between natural justice for the accused and fear of standing up for the victim.
This process should also include a mechanism for appropriate feedback to those who raised issues either directly or through their representative.

We also believe we should implement (non-disciplinary) subordinate 360 review for all practitioners once every 5 years and peer support to discuss outcomes. All clinical leaders, service managers and HR Practitioners must show competence at not simply behavioural appropriateness but how to manage challenging (behavioural) situations and proactively engender a positive workplace environment.

All DHB risk registers should also include workplace stressors as a risk to employees of inappropriate behaviour and all DHB cultural change programmes should be monitored to identify what works and what does not work – and if so, why.

Finally, we need to commence action on the issue of sexual harassment. In 2018, NZRDA surveyed its members on this issue following up from the 2015 survey. We found things had not demonstrably improved. Of the 503 responses 65% were female, 35% male and of these individuals, 85 doctors reported they had experienced and 56 witnessed sexual harassment in the past year.

The main perpetrators of sexual harassment against RMOs (experienced and or witnessed) were patients (60%) and SMOs (38%). The remaining 2% was made up of nurses, other RMOs and managers. Of SMO cases, 23 cases of actual sexual harassment were reported to us through the survey and 29 cases of an RMO witnessing an SMO sexually harassing an RMO were reported. Notably after experiencing and / or witnessing sexual harassment in the workplace, only a third of respondents reported/raised a concern with their employer and only 40% of those RMOs were satisfied with how the complaint was handled.

Of those that didn't report, the vast majority cited the fear of career retribution or other negative implications as the reason they did not report.

The highest incidence of sexual harassment by a patient was reported in ED, and by SMOs from general and orthopaedic surgery. General Medicine had the highest overall incidence reflective no doubt of the numbers of people involved in this, the largest of services.

The comments from the survey were particularly enlightening. The lack of effective, fair and/or safe processes for addressing allegations of sexual harassment is deeply worrying. We will never get on top of RMOs lack of confidence in the system whilst this continues to be the case. Unfortunately, whilst it continues, we won't get RMOs making complaints and

a vicious cycle is perpetuated. NZRDA is available to assist and support any RMOs who experience sexual harassment, including advice on what might happen and keeping DHB systems on track and DHBs accountable.

Of course, this is all well and good, but the fear of career retribution will still inhibit all but the brave or (career wise) most secure of our members.

Patients as offenders is another issue that needs addressing in a different manner. The DHB's are responsible for ensuring we have a safe workplace – and clearly, we do not have that at this time. In 2019 we need to formally raise this with the DHBs to see what can be done to ensure a safer workplace. Coordinating with NZNO might be a useful approach given our nursing colleagues suffer as much if not more than we do in this area.

As I said, I had hoped that this generation of RMOs might be the ones to say, "this stops here", that the damage and distress countless RMOs endure because of inappropriate behaviours and the perceived impact of career retribution might not be passed onto those that follow. It is often said that "the standard we walk past is the standard we accept" – if we all stop accepting poor standards, if we all stand up, then there is some herd immunity, some protection afforded us. But as the recent story of Dr Kokoda demonstrates all too graphically, it is not that easy and maybe simply too hard to achieve from the bottom up.

We do have a better situation here in NZ than that of our colleagues in Australia, largely I believe, because of the collective strength of RMOs in NZ through NZRDA. NZRDA acts by its very existence as a limiting factor, a threat maybe, that there is an organisation, that should we get the chance, will do something. We will support RMOs, we will take cases if able to do so and we will keep these issues on the agenda.

I am equally realistic that NZRDA itself can only do so much. If this is to stop here, we will need RMOs to be brave and to stand by that commitment. Whilst I would love to think that was possible, I am equally realistic about how much we would be asking of this generation of RMOs to make it so.

COMMUNICATION PLATFORMS

We have spent some time this year improving our communication systems and platforms. This has included:

- Refreshing all pages on the website during which each page was reviewed, old content removed and/or updated as appropriate, and layout reorganised.
- We have added new content categories to the websites. For example, videos of delegates and the interactive map of schedule 10 progress.
- Our Facebook page was rejuvenated, and the followership has doubled to more than 5000. And we've done a livestream on Facebook (and are well set up to do more).
- Launched an RDA account on both Twitter and Instagram. Whilst we only have a small following at this time, we hope to see this grow. If it doesn't its utility will be reassessed.
- And we have launched our Vimeo account, which is where we manage our online video content.

We still have more to do and a workplan to improve the website in particular is underway and will continue into 2019. Part of this work includes CNS reviewing our service contracts with website support providers.

Engagement on the social platforms comes in waves. When there is a dispute or some controversy, the engagement increases, and our followership grows. We will watch what happens to our presence on the social platforms once this MECA dispute is concluded.

GDPR REVIEW

On 25 May 2018, the European Union's (EU) General Data Protection Regulation (GDPR) came into international effect. This is a law which regulates the data protection and privacy of all EU citizens and applies to all international organisations that may process the information of EU citizens.

Given this scope, the GDPR has important implications for many New Zealand organisations including the NZRDA, and we are beginning to make changes to ensure compliance.

The GDPR will impose stricter requirements. In particular, the GDPR will require us to gain the "active consent" of our members in order to use their information for a specific purpose and more information must be provided to our members on what we are using their information for. We must also keep accurate records of any collected data, its authorised uses and any disclosures and security measures.

As we are the data controller that engages subcontractors to process information, we remain responsible to ensure these subcontractors are GDPR compliant. As a result, all contracts must be reviewed, and data processing agreements included in all agreements going forth.

We will also appoint a Data Protection Officer to train staff going forward in order to ensure this compliance is being maintained at all levels.

MECA

Having initiated bargaining on New Year's Eve 2017, negotiations commenced 6th and 7th March 2018. Whilst some time was taken in the first meeting to argue over the BPA (Bargaining Process Agreement), we did table our claims which included:

- Pay increase
- Additional steps on the salary scale
- Reduction in weekend frequency
- Increase to medical education leave
- Increase to "no 8-hour break" penalty payment
- Increase to on call allowance
- Increase to cross cover payment
- Moving schedule 4 ED provisions into the body of the contract
- Increase to protected training time
- Improvements to transfer expense clauses
- Moving schedule 10 into body of the collective and thereby applying to all non-shift rosters

The DHB bargaining team provided some idea of what they were after although these were more themes than actual claims and included:

- Differentiation of arrangements for different RMOs
- Delivery of training
- 2/3's agreement
- Remuneration model
- Schedule 10
- Defining the role of an SHO

After several delays at the request of the DHB team and several meetings with little progress what became clear was that the DHB team wanted to spend considerable time investigating what they claimed were the negative repercussions of Schedule 10 and to explore alternative

remuneration models. Whilst the DHB team assured us they did not want to "roll schedule 10 back" (to pre schedule 10 provisions) they did not go on to explain what it was they were actually seeking. For the remuneration model they hinted that they were prepared to invest sufficiently as to make removing the second paragraph of clause 8.1.2 feasible but again were light on detail.

In May, we tabled our position being 4% pay rise, 14-month term, removal of deduction model, a consideration of loosening up on mid-week rostered days off, implementation of all Schedule 10 rosters by December 2018, however this position was rejected by the DHB team. They were unwilling to make an offer themselves but stated that no settlement would be agreed without addressing their Schedule 10 and remuneration model claims.

In an attempt to resolve the Schedule 10 concerns, a national hui was considered by the parties however the DHB team wanted to put bargaining on hold until the hui had been held. The outcome of which would drive the bargaining, whereas we wanted to complete bargaining and then enter into conversations around addressing any issues that had arisen from the implementation of Schedule 10 rosters. We then explored the formation of a group that could visit individual DHBs to work on resolving any potential problems associated with Schedule 10, but again when this took place it was a sticking point between us.

NZRDA did join with ASMS to establish a MoU to support resolution of any issues arising from Schedule 10. Both unions acknowledge that training through an apprenticeship model based on service provision has served New Zealand's health system well by producing a highly trained medical workforce. And also, that fully aligning training and service provision can be challenging especially when achieving safer working hours and may impact on continuity of training, clinical handover and continuity of patient centred care normally provided by registrars. We both identified that this challenge and these consequences have predated Schedule 10, but the issues might have been exacerbated by it.

ASMS and RDA also agreed that the approach to addressing these unintended consequences is not to make RMO hours of work less safe or removing (or reducing) agreed protections. We further agreed on the importance of a whole of medical team approach to the 24/7 delivery of patient centred care. NZRDA supports ASMS concerns at the unacceptable, unsafe and precarious state of the SMO workforce, which is characterised by significant shortages, increased workloads, lack of work-life balance, high burnout, presenteeism (including working while infectious), and a retention crisis.

A lot to work on but then also a lot to risk and gain. The drive of the medical profession to do everything they can for their patients coupled with a lack of balance regarding their own welfare and an astounding lack of concern from employers to the wellbeing of this professions members is creating a serious workforce challenge.

The main principle of the MoU is therefore to ensure any unintended consequence is resolved swiftly and as close as possible to the affected service including agreed trials of alternative implementation arrangements. The RMOs and SMOs have NZRDA and ASMS available to assist if necessary and we can call on mediation assistance if it is necessary.

Whilst invited to join with us, the DHBs refused, preferring to see through the industrial approach first. In a nutshell, they preferred their chances to unilaterally imposing their will on NZRDAs members, rather than having to work in a consensus-based tripartite forum

And so, bargaining continued. The DHBs tabled two alternative remuneration models both of which would result in a pay cut, more unsocial hours being rostered and shift rosters being more attractive. The DHBs then revised their claims in September to a log considerably wider and more negative than those tabled in March and May. In addition, they now had claims including (but not limited to) reducing the role of the NZRDA, change to the run review process, dropping the minimum period paid for call backs, change to the definition of cross cover, weekend abutting entitlement applying only to annual leave, locums to pay for all employment related expenses, DHBs to have the right to share personal information across employers; the list went on.

This additional list coincided with SToNZ forming a union and entering bargaining.

After months of bargaining it became clear that the biggest issues were DHB clawbacks in regard to:

- Remuneration model changes
- Changes to Schedule 10
- Decision making

In November, we moved to mediated bargaining but still there was no movement on the “big three”. Then in December, the claim around changes to remuneration model and “2/3s agreement” were withdrawn but for those clauses that require agreement to vary the contract through agreement with the NZRDA was still very much on the table. On New Year’s Eve

2018, strike notices were issued with the first strike taking place 15th January 2019 for 48 hours; three more strikes have taken place since.

The DHBs proposed two alternatives to contract variations, the first being a "sunset clause" whereby there is an extended consultation escalation process with the DHB having the final say and a second proposal that grants the union the ability to advise its members on the issues associated with a proposal but the DHB having the final say.

We tabled an alternative that involved a third-party review when agreement could not be reached to a change proposal, however the response was that the DHB must have the final say on whether to accept the reviewer's recommendations. They also extended that "final say" wider than contract variation clauses including every change that goes through the '2/3's agreement' process.

The themes for this round of bargaining would include frustration and delay, changing positions with claims being taken off the table only to reappear later, and a desire for power and control by the CEs. No doubt the formation of SToNZ and subsequent settling of their contract had a role to play in emboldening the DHBs to table more extensive claims and resist strike action. At this stage, we are waiting for facilitated bargaining and further strike action in order to bring this saga to a conclusion.

GPs

In May 2018, the RNZCGP GPEP collective was settled with the main changes being an increase to reimbursement for costs, college discretionary leave was changed to study leave, and National Executive members can now take 3 paid days per annum. There were changes to Parental Leave provisions to make it more equitable and the Rural and High Needs Practice Lists were updated. Of course, a salary increase was achieved too. One of the biggest changes was also the longer term of 18 months which was to provide for a greater period between bargaining rounds but to also provide for GPEP 1 members to be more engaged with bargaining.

Since then, several issues have been raised including:

- Transfer expenses when not transferring to a rural practice; and
- Assessment of previous experience when determining salary steps; and
- Parental leave impact on salary.

Bargaining is about to commence again, no doubt with these issues being raised as claims along with a pay increase.

Advice around individual contracts to those registrars moving from their GPEP 1 year into private practice employment in the GPEP 2 year was again in great demand, with a variety of both employment agreements and independent contractor arrangements. The template Individual Employment Agreement available on the website continued to provide a baseline.

Work on building a relationship with the College continues, including a number of engagement meetings (either via phone or face to face) to ensure communication channels are maintained: it is intended to increase the frequency of these meetings going forward.

NZRDA also participated in the South Island rural medicine training programme with the aim of streamlining this programme to better enable registrars to move location and achieve the requirements of the training programme without having to resign or source their own employment. This work will be on going with participation from the NZRDA, DHBs, Trust

Hospitals and the RNZCGP Rural Medicine Division.

In May 2018, the RNZCGP held a working group meeting to discuss how to best respond to changes in general practice. Attendees included NZRDA, a number of GPs and relevant persons from the RNZCGP. The main topics of discussion were: Changes in Workforce, Existing Pressures, Technology, Maori Health Outcomes, Collegiality and Mentoring and an Advocacy Group. This working party made recommendations to the College Board.

At the NZRDA Health and Wellbeing Conference held at SKYCITY in November last year, Dr Caroline Christie from Pegasus spoke about self-care for health professionals. She talked about how Pegasus Health developed a pastoral care programme for GPs and she addressed issues of self-care, education, workforce demographics, and improving clinical effectiveness. Following on from our Conference, improving access to education and resources around health and wellbeing for those working in GP land is on our work plan.

Speaking of which, the work plan for community care also includes increased engagement with members and clarification around the benefits of remaining with the NZRDA when no longer College employed. Last year the 'Community Doctor' newsletter aimed at all members working in the community including public health and not just GPs.

INDIVIDUAL CASES AND COMPLIANCE

PGs and Disputes

Whilst perhaps taking a "back seat" to the (ongoing) negotiations, there were still numerous compliance issues and related disputes during the year that required attention.

Given the shortage of RMOs across the country, the ability for RMOs to take leave has been an unsurprising tension with RMOs feeling pressure not to take leave as it leaves remaining colleagues working an understaffed roster, an issue exacerbated by the lack of urgency on the part of the DHBs to recruit the additional RMOs necessary to fill Schedule 10

rosters. Recruitment and retention difficulties will not disappear anytime soon, so we expect this to continue to be an issue for at least the immediate future.

Reimbursement of training costs also continues to demand our time with several DHBs resisting reimbursement giving excuses (amongst other things) as such not being required until the RMO grill admittance onto the training programme. This is a constant frustration which, when challenged, is invariably successful (for the RMO), but we seem to have to constantly be challenging on behalf of someone somewhere. The DHBs have also refused to update the agreed "costs of training list": this list was created at the DHBs request to make it administratively easier for RMO Units to know what could be automatically reimbursed. It is not an exhaustive or inclusive list however, things not on the list are still reimbursable if they fit the criteria of the overriding cause. The failure to update the list again goes to the DHBs use of any mechanism to undermine terms and conditions of employment for RMOs.

Challenges around the legitimacy of cross cover claims was a new feature with DHBs demanding to know exactly what tasks an RMO performed whilst covering for a colleague, particularly when house officers were covering absent registrars. When the house officer concerned provided such information and with the assistance of the NZRDA the claims were usually honoured. In relation to cross cover, in an attempt to streamline reports of cross cover outside ordinary hours an online reporting system was developed for the NZRDA website. There was a flurry of reports submitted when this was first implemented but does not appear to have been used much thereafter. Whether this was as a result of no instances to report or members forgetting it was available is hard to determine but we suspect it is the latter.

The issues that required our assistance on an individual level were mostly associated with performance, including RMOs not passing runs and competency related concerns. It is positive that members have been contacting us earlier on for assistance resulting in our being in a better position to give advice at the start of the process and support these individuals throughout.

We have had several members who have been subject to a return to work plan after taking a period of time off work and then encountering difficulty in getting their employer to agree to implement that plan. These matters often involved members who had taken a period of leave due to health reasons and were then ready to return to the workplace but with reduced hours

or work levels. These situations invariably result in multiple meetings and require ongoing assistance to ensure the members in question are supported fully with reintegration and that short- and long-term plans are not just established but honoured.

We have dealt with several cases whereby members have been questioned for excessive usage of sick leave often related to burnout, which ties into not having adequate staffing levels as referred to above. And we have had 5 cases of bullying this year and two of sexual harassment: one on behalf of a victim and one RMO who was the accused.

Finally, we continue to have complaints involving privacy breaches including instances whereby RMOs have looked at notes of a patient that they were not responsible for. It would appear that despite numerous publications reminding members of the requirements around patient privacy we will need to include in our workplan going forward a reminder to members about the importance of patient privacy and the obligations associated with this given the seriousness of the ramifications.

MINISTRY OF HEALTH / HWNZ

In 2018, we saw the appointment of a new Director General of Health, Dr Ashley Bloomfield. Dr Bloomfield is a public health physician, and previously worked in the Ministry, then DHB Planning and Funding and was the CE of Hutt Valley DHB before taking up this new role.

Ashley has made it quite clear he intends to stamp his mark on health. It has been reported to us that this includes “getting the unions under control”. The Ministry was restructured and HWNZ effectively disestablished. Prof Des Gorman resigned early this year making way for a new workforce and ER directorate in the Ministry.

Impacts include:

1. The medical reference group under HWNZ has gone into abeyance. This group with representatives from all the medical bodies had formed a cohesive one stop shop for issues medical. Remarkable cohesion and consensus were achieved through this group.

2. The concept that work force should lead ER is still talked about, but the ER section of this directorate has grown whilst the workforce side not at all. All DHB bargaining now has to go through the Ministry ER team and DHBs are bowing to whatever instruction they receive from this central agency.
3. The HWNZ vocational training money (~$160mil) is now entirely in the hands of the Ministry. This money was paid to the RNZCGPs to run GPEP including pay the registrars salaries, as well as to DHBs as a partial subsidy for our training. $10mil of this money had been earmarked for an innovation fund. Groups submitted ideas to HWNZ last year for workforce projects that required financial support. The fund was open to everyone (not just medical) and HWNZ received over 100 submissions. That is where the process stopped. We understand the $10mil was redirected by the Ministry to pay for a midwives settlement amongst other priorities: we have yet to see any of the innovation submissions be actioned. If the Ministry can redirect money in such a manner, it behoves us all to think about what might become of the rest of our vocational training money.

We have recently undertaken an OIA of the Ministry around their medical pipeline strategy to see what they might be thinking.

Whilst the medical reference group has been in abeyance, the Ministry did form another group comprising many of the medical bodies in late 2018. We were first called about this initiative and informed it would be a small group to look at any impacts arising out of Schedule 10. We agreed that would be worthwhile but were clear that only key stakeholders and those with the authority to both engage and take responsibilities for outcomes should be invited. We saw those stakeholders as ASMS, DHBs, ourselves and CMC. MCNZ was suggested in a chairing role. Having people without authority risked a talk feast of people who neither knew what was happening on the ground or would accept responsibility for any outcome.

When the meeting invite arrived however, our understanding (and that of ASMS) was found to be incorrect. A myriad of bodies were invited including those without any skin in the game. The invitation list also included SToNZ who oppose Schedule 10. And the meeting agenda had expanded with potential impacts on the bargaining that was underway. The Ministry summarised the issues for discussion as:

"...workforce issues that are affecting the medical workforce of RMOs and SMOs. These issues impact across the entire medical workforce and those working or training with them, including other clinical staff, administrative staff, and students. We have all seen or heard reports of presenteeism, fatigue, and burnout and are aware of the potential impacts these can have on patient and staff safety. When considering any approach to these issues we need to take into account ensuring good patient care, effective service delivery, and the ongoing training and development of the workforce. These are not easy issues to balance and we need to take a wide view of possible approaches and impacts."

We declined to attend as did ASMS who noted that *"the purpose of the meeting was linked to the DHBs overall collective bargaining strategy which we believe is condoned by the Ministry of Health. The issues ASMS wants to focus on need to be addressed in a way not linked to this or any other collective bargaining strategy. Further, the already advised non-attendance of RDA makes the proposed meeting pointless."*

RELATIONSHIPS WITH OTHER PARTIES – CMC, NZMSA, ASMS

We worked well with CMC this year, attending two of their meetings to discuss aligning dates with Australia and the abolition of confidential references and referees. We also supported the Choosing Wisely to campaign however noted that until SMOs buy in, we will still be faced with requesting the serum rhubarb at their instruction.

We also shared concern over Health Workforce NZ's intentions for the $160mil vocational training subsidy given to DHBs which is reported on elsewhere.

Likewise, our good relationship with NZMSA continued with regular engagement directly but also through forums such as the professional behaviours taskforce.

Likewise, with ASMS where our mutual interests were reinforced this year not only with the advent of SToNZ and the MECA dispute but also changes at the Ministry also reported elsewhere in this report.

PART TIME OPPORTUNITIES

The MECA provides for DHBs to commit to a positive process of introducing part-time employment opportunities for RMOs, however we still struggle in this area. Too many RMOs end up job sharing in the absence of any alternative. Job sharing is inherently less stable than part time employment as it does not guarantee the job or hours of work. You are dependent on the job share partner to continue with the role as mutually agreed for your own job security: if one resigns the partner must either complete the full role or lose their job also.

More work with the DHBs on this issue is needed as it will clearly take dedicated effort to improve opportunities for members.

REVIEW OF HOSPITALS

The Review of Hospitals caused a little stir this year. The DHBs were provided with copies as they always are and wrote to us a month later concerned at some of our content. The DHBs complained that the review went “beyond what the DHBs consider acceptable public comment”.

They referred to the opinion expressed regarding the efficiency, appropriateness and efficacy of some RMO units and the impact such commentary might have on trainee intern decision making about which DHB they might chose to work at. The DHBs remained silent however on why it had come to pass that RMOs felt the way they did and what actions the DHBs might take to improve this reality, albeit from our perspective.

The review of hospitals has been published in the same format for literally decades. The review is, and always has been, "opinion" "unofficial" and "subjective”: of note, it has never received such a complaint from DHBs before. The DHBs letter also solely focused on negative commentary with no reflection to the positive comments made ignoring the balanced nature

of the review. We noted that in response to many of the positive comments, individual DHBs had expressed thanks. And some also took the initiative to do better: both Northland and Waikato DHBs subsequently contacted us with ideas on how they might do so.

The implication in the letter that DHBs actions are always worthy and just, and they contribute nothing to any element of a poor outcome in our relationship has been present for some time but came very much to the fore in 2018. The MECA dispute is just one example but this letter also. In reply, we attempted to steer the conversation towards a more reflective and constructive way forward. The review is written by RMOs and importantly we noted it is how they feel. Rather than complaining about how the RMOs feel and maybe blaming the messenger, we suggested we reflect instead that they do (feel this way) and that we need to make changes to enable improvement.

The denial of RMOs' rights especially under MECA underpinned a lot of the feeling expressed; the failure to see RMOs as anything more than a number on a roster, poor process around many of the RMOs' entitlements, inadequate cover for leave, inappropriate behaviour and bullying… are all examples of influences that impact on this issue. We further noted that whilst we have agreed that RMO Units are often the "meat in the sandwich", they are also all too often left in that state by DHBs which fail to resource them appropriately which in turn continues to have negative impacts on the RMOs. We posed the question: is it really any wonder that in such circumstances, many RMOs feel the way they do?

But by the same token not <u>all</u> feel this way, living proof that we can do better. We suggested this was an opportunity to do so commenting that it certainly could not please us more if next year there was nothing negative to say – achieving that honestly, however, required us to recognise all is not well today and setting our sights on improvement.

Unfortunately, the DHBs collectively did not take up our offer to work together on this initiative.

NZRDA does try to work with DHBs to improve the environment within which RMOs work and DHBs operate. As examples:

1. Producing a guide to "what make a good RMO Unit" albeit our view.
2. Actively supporting cultural change programs in DHBs.

3. Calling together various stakeholders including DHBs to give opportunity for proactively dealing with issues (accreditation loss, TI to HO transition, inappropriate behaviour etc.).
4. Welcoming DHB managers into our offices, to work collaboratively, including giving some insight into our perspective.
5. Working tirelessly to assist a smooth Schedule 10 implementation.
6. Enabling a clinical governance training programme for RMOs.
7. We constantly work with DHBs to improve MECA compliance.

Should we bow to the DHBs preference we "sanitize" our commentary in the Review of Hospitals?

After all, what was said was from the RMO perspective and it was honest. I cannot see how ignoring what it is to be an RMO, what you experience, or silencing descent will assist. I do believe the DHBs ability to reflect on their own contribution to the poor relationship we have, their insistence on a "right to manage" overriding the views, aspirations, rights and desires of RMOs is a barrier. I am not saying NZRDA has not contributed to the relationship, of course it has, it is our relationship, but I do believe we have become reactive, and been dismissed when we have sought to work together to a better end.

The one exception this year may have been Whanganui. Interestingly, the Whanganui RMOs had some subsequent qualms about their own report in the review of hospitals, not on the basis it was inaccurate, but rather it showed Whanganui in a poor light and that may further exacerbate recruitment to the region. Post ACE, Whanganui ranked the lowest in TI preference. When we checked with the TIs, their reasons included the slow implementation of schedule 10 and dissatisfaction with the manner in which RMOs were managed. Whilst the review of hospital had influenced them, it was more that it reinforced their own knowledge largely as a result of word of mouth and personal experiences.

The Whanganui CE decided to try and turn this state of affairs around and a meeting was held. It was a difficult few hours with some challenging conversations and behaviours. From the perspective of my role and longevity in the system, I found the level of paternalism towards RMOs deeply disturbing. Pat/Maternalism can have benefits: pastoral care, mentoring, supervision, security and safety professionally and personally. But it can also deny opportunities especially when key decisions that impact you are being made. The idea that

someone of my age automatically knows what you are experiencing, and what your aspirations are let alone key elements of how you do your job is poorly founded. If such views are made on the basis of "I know what's best for you", we are almost inevitably doomed to make mistakes and lose opportunities.

One example is the implementation of a new task manager for ward calls and other duties. Who best to know what works than you, the people who live and breathe this work? If I had been asked, I would have referred to the Dunedin system as that the RMOs prefer, or maybe the Waitemata one, on the basis of what you have told me. Better still however, just ask your RMOs!

Whanganui did implement Schedule 10 and have become more responsive to their RMOs. Complaints into the office have dropped off although that may be in part a reflection of the 4 fabulous delegates, we now have in this DHB. I look forward to reading this year's review of hospitals.

ORIENTATION AND TI TO HO TRANSITION

In 2017, NZRDA become increasingly concerned at the impact of transition from TI to House Officer on some members. At one end of the spectrum, individuals were finding the transition so difficult they had to be withdrawn from work and reintroduced in a more supportive and planned manner. Members also expressed concern that they "hung on in there" but that the experience was incredibly stressful and detrimental to both their own wellbeing and potentially that of their patients.

Already aware of an increasing number of instances where intervention and support were being required, we found ourselves representing new colleagues where their employer failed to provide sufficient support or respond appropriately to members in difficulty. In one case, this required the threat of a personal grievance to get matters back on track.

To try and get ahead of this issue, NZRDA started this work programme incorporating a number of areas needing attention:

1. Orientation must be improved and focus on practical knowledge doctors need.
    a. We felt a core nationally consistent clinical orientation is required to cover the essentials a new doctor needs to know, (acknowledging the local information and HR requirements of orientation also).
    b. And that all DHBs should include the provision of a HOTTI (House Officer Teaching Trainee Intern) peer to peer course run by house officers for all TIs.
2. The buddying system should be provided universally to all new House Officers.
3. That the TI year be acknowledged as a "training to be an intern" year as the priority.
    a. That we work with the universities to reduce the academic component of the TI year (push back into the first 5 years) to ensure TIs are free to attend with their teams especially when on medical or surgical runs.
    b. Where 4th and 5th year students are also present on wards, the distinctly different role of the TI should be made clear and actively delivered upon. This includes alignment of TIs within the House Officer/Registrar team.
    c. That limited registration is considered to enable TIs to undertake a higher degree of (appropriate) responsibilities.

4. That House Officers and Registrars have available to them “teach the TI” courses. Not only would this help with TI learning but all levels of ongoing learning throughout the doctors working (and teaching) lives.
5. That specific “new doctor mentoring/supervision” be provided including psychological support during the first month as a minimum to ensure the wellbeing of our newest and potentially vulnerable colleagues.

We arranged a meeting of all stakeholders and gained considerable agreement on the above. All parties left the meeting with objectives to pursue.

Again, the MECA dispute took resources away from all of the above, but we have introduced the HOTTI programme, improved buddying, and made many orientations more effective and clinically focused. Work on improving the TI year itself demands the active engagement and support of the universities which we don’t yet really have as they are concerned at the risk TIs may become employees (and cost shifts that would result). None the less, our 2018/2019 transition has seen less need for intervention than the previous 3 years suggesting that what we have managed to achieve has made a difference.

We are also mindful of the need to look at House Officer to Registrar, and Registrar to SMO transition. Both these periods are stressful times in our lives which should be better managed.

MCNZ

2018 saw a continuation of productive work alongside MCNZ. Whilst we don’t always agree, we have a productive working relationship that has facilitated at least some improvements for RMOs.

CBA: The Auckland region continued to block the CBA processes until the Minister of Health imposed a requirement to meet MCNZ timeframes in his letter of expectations. The Auckland region are still holding out to the last minute, appear to be trying for the cheapest option in terms of salary as a priority (not training benefit) and also focusing on quasi hospital runs such as psychiatry and paediatrics. The latter issue, despite NZRDA

surveying members at the DHBs request and feeding back the most valued runs from an RMOs perspective are GP, hospice and A&M.

Curriculum Framework and Report: Whilst MCNZ continues to resist the provision for a RMO representative position on the medical education committee in favour of individual RMOs we have continued to work on improving the "tick box" problems with eport and have also participated as the RMOs' representative body on the curriculum framework review. Not the most thrilling of topics perhaps, but still an important one.

To recap, MCNZ introduced the new prevocational curriculum framework (CF) for 1st and 2nd year house officers in March 2014 after quite a period of gestation that started in 2008! This review was scheduled at that time to ensure we audited and monitored the effectiveness and meaningfulness of what was a "new and unique" programme, internationally speaking.

The original intentions included to:

- Make it clear that the CF is an achievable minimum list of skills and competencies.
- Implement a high trust model that does not require evidence of achievement of each skill and competency.
- Ensure the framework allows the capacity to recognise prior learning, what the gaps are and to build on education and training from medical school.

Overall, we (collectively) thought the CF was working well but all raised concerns over the "tick the box" process as well as there being too many boxes to tick. We all agreed that maintaining the high trust foundation, adult learning principals and reflective process were important. We reiterated that it must be meaningful and useful for the doctors and also felt better vertical integration into the TI year should be fostered.

Eport needs improving and we again pushed for an app.

On the issue of there being too many specific objectives, we discussed grouping the objectives better (less boxes to tick), using examples rather than objectives and the concept of EPAs arose which the committee has now devoted a lot of time to exploring further.

EPAs or Entrustable Professional Activities are "doings" rather than lists. They identify a series of activities (admit an acute patient, for instance) that many of the objectives would come under. The individual is then judged to be a "novice" (AKA TI as this is the starting

step) through to “trusted to do independently” or even “able to teach others”. Whilst educationally speaking there may be merit in this approach, our psychiatry registrars (who already have EPAs as part of their training programme) did not believe it was appropriate for house officers and also raised concerns about the resource (SMO in particular) the system demands. Despite all agreeing that adding more workload to SMOs at this time was not an option, the enthusiasm amongst some to explore further remained. This will need to be monitored carefully. If the enthusiasm materialises into a desire for change, we will need to ensure it adds real benefit to the training of house officers and is “doable” within the constraints of our system or risk more work for all without equivalent benefit.

An independent firm has also surveyed RMOs, SMOs and DHBs on the CF, repeating a survey that was done prior to implementation to judge benefit. Their response rate was extremely low however so the value of this piece of work will have to be judged accordingly.

The 10-week rule: We reported on this in the last report having been left with MCNZ’s verbal reassurance that the 10 weeks was only a guideline and that they would consider any specific circumstances as they applied to an individual.

A number of letters and a meeting have followed, and we are still at an impasse to resolution. MCNZ have adjusted the guidelines making the 10 weeks related to any 40 hours in a week, however would not agree to 400 hours a quarter. They have also included study or Medical Education and sick leave within the 40 hours,

We intend to try again with a suggestion that should an RMO not meet the 40 weeks, an automatic review occur by someone outside that DHB and without the name of the RMO being known to them. The concept that a first year would appeal to their own intern supervisor let alone the MCNZ itself is unrealistic, so a more effective mechanism of appeal or review may at least get us some fairness.

On a related note, discussions amongst colleges about the issue of time served versus competency is also occurring. More on this issue across the board may arise in 2019.

HEALTH, SAFETY AND WELLBEING

Wellbeing Conference

The Health and Wellbeing Conference took place at SKYCITY Auckland Convention Centre on the 8th and 9th of November 2018. This event was sponsored by the NZRDA Education Trust and New Zealand Medical Professionals Indemnity Insurance. The aim of the Conference was to promote and advance health and wellbeing for Resident Doctors across New Zealand. We had around 150 attendees including more than 100 RMOs and other stakeholders such as SMOs and DHB Executives. Notably however, unlike the clinical governance conference held two years earlier, we had no CEs or CMOs attend the wellbeing conference.

Day One included an Opening Address from the Hon Dr David Clark and a presentation from Dr Peter Lim from the Royal Prince Alfred Hospital in Sydney. Dr Lim spoke about the BPTOK pilot wellbeing programme being carried out which aims to improve the psychological and physical wellbeing of physician trainees in addition to teaching trainees to maintain their health throughout a long career in medicine. Other presentations included a talk by Dr Karyn O'Keefe from the Sleep / Wake Research Centre on improving sleep and fatigue in RMOs. In the latter part of the day several RMOs and an SMO spoke about their own personal struggles with maintaining good health and wellbeing and learnings from actions taken to better their situation.

Day Two included a presentation from Dr Tony Fernando who spoke on mindfulness and compassion for doctors and a speech from Dr Cathy Ferguson, a surgeon and Vice President of RACS, on discrimination, bullying and sexual harassment. The latter part of the day consisted of breakout sessions whereby attendees took part in practical workshops on:

- How to Prevent Burnout – resilience building and relaxation techniques,
- Psychological First Aid – helping prepare people to respond to a person who may be experiencing emotional distress in the workplace,
- Psychological Flexibility – unhooking from internal mind and being present,
- Organisation Health and Sustainability – building a best-fit culture of wellbeing and employee engagement for the good health and sustainability of organisations, teams and individuals.

This session moved onto explore practical ideas identified by the attendees to assist RMOs with bettering and maintaining health and wellbeing. These included the topics of: Napping, Cake and Chat / Debriefing, Mentoring Facilities / Buddying, Fatigue Managing Systems, Sharing Stories and Accessing Support and an NZ equivalent of a (BPTOK) wellbeing programme.

The feedback from the Conference was overall positive with attendees commenting *"This conference came at a time in my life where I really needed to see the big picture again outside of work. As a result, I feel that my health and wellbeing has directly improved. Thank you to all the amazing and inspiring people involved in putting this conference together - my only wish is that even more people could have attended! Big thank you to the sponsors for funding this incredible event"* and *"Far exceeded my expectations. I have never found work as an RMO stressful, however I learned in this conference that my lack of stress is due to my ability to compartmentalise my reactions to long hours and difficult interactions, a coping mechanism that in itself puts me at risk of denying the effects of stress until it could be too late. I found the speakers engaging, particularly the two doctors who shared their own mental health breakdowns. I went with no expectations and was pleasantly surprised. Thanks for a great conference".*

As with too many issues this year, our ability to keep progressing the agenda has been hampered by resource allocation to bargaining. Over the course of 2019 however we will be developing our health and wellbeing related resources available on our website and will be doing work to expand and implement these topics (mentioned above) and discussed at the Conference.

Headspace

Headspace was launched to members (including TI members) on 15 June 2017. The opportunity to continue to access headspace for a second year was continued in 2018 to assess reuptake rates amongst other parameters but will not continue past this current year. The balance between NZRDA introducing members to opportunities to improve mental wellbeing and the importance of self-care was stressed.

EAP

Employee Assistance Programmes are provided by DHBs for staff as a "confidential" service. They provide access amongst other things to councillors and psychologists for stress related workplace issues. As part of our investigation into what was available to support resident doctors' health and wellbeing, we undertook a survey which identified that around 75% of RMOs do not know what EAP is. The 25% that did know and have used it however, found it helpful.

The issue of confidentiality was of concern to many, the clear belief amongst those that did know of EAP was that it was not confidential.

We had intended to do some more work in this space this year, engaging with the DHBs around how to effectively maintain confidentiality, and the level of experience of practitioners at the end of the phone. Unfortunately, again due to the pressure of work from MECA, this work has had to be put on hold. Hopefully we will be able to progress this in 2019.

In the interim, NZRDA did make a fund available to assist members in need of psychological support for whatever reason. This fund is being monitored as to need and utilisation through the office.

EDUCATION TRUST

The Trust has had another successful year with continued support from the Trustees. During the year the decision was made to move some of its investment portfolio to a new fund after receiving external advice from experts in the field. The intention is to further diversify the portfolio in order to maximise returns.

The Trust provided support for 2 major events this year: a clinical leadership programme and the health and wellbeing conference, as well as other smaller projects.

A significant level of financial support has been given by the Trust to the clinical leadership programme for RMOs this year. Having completed and paid for the trials all stakeholders including the DHBs noted its success. Whilst DHBs were talking about next steps and stated a keenness that the momentum and interest built in the pilot continue, when it came to self-funding, they appear to have lost interest.

As noted above, NZRDA also ran a large health and wellbeing conference which was open to RMOs as well as other health professionals in Auckland in November 2018. The cost for a group of RMOs to attend was provided by the Trust.

The Trust has agreed to continue to provide support for the training of RDA delegates both at the regular annual 3-day event and for a couple of smaller 1-day programmes during the year.

We continue to try to raise awareness of the Trust and thereby encourage more grant applicants to ask for financial assistance for projects which fit with the objectives of the Trust.

PROFESSIONAL MEDICAL INDEMNITY INSURANCE

NZMPI is the only 100% NZ owned insurance company insuring RMOs, SMOs and GPs, including cover for those undertaking temporary work overseas and charity work in the Pacific. NZRDA owns 15% of NZMPI, having supported its establishment some 20 years ago. At that time, NZRDA was concerned that the only available option was through overseas based friendly societies with discretionary cover and wished to ensure there was a contractually binding insurance option also available for doctors; one that was NZ focused and operated.

Times have changed since then, however. Internationally, the insurance industry was rocked by 9/11 as well as a number of other well-known disasters, including NZ's own. The Insurance (Prudential Supervision) Act introduced in 2010 was a move by government to ensure minimum standards, including sufficient assets being available in all insurance companies to protect those they insure. NZMPI was able to comply with this legislation without issue.

In 2017, NZMPI was re-categorised as a "large insurer" albeit not a very large one. This change is determined by the Act which defines as "large" all insurance companies with a net premium over $1.5 million. The change will be brought additional compliance requirements (and costs) all which NZMPI met.

A significant surge in claims in 2017-2018 mandated a premium increase in 2018-2019, the first in over 10 years.

SUMMARY

As I reflect on the year that has passed, and the 29 that came before that, I have seen many struggles, much success and much change and yet there is always so much more to do. For many years in my role, I did what RMOs didn't want to or couldn't do; by the time I had not just left practicing clinical medicine but also decided I would not return to it, career retribution was no longer a threat for me.

Whether I was enforcing the MECA or being the public face of the Association in the media, my working life inevitably ended up in the public spotlight. I have nonetheless been surprised how the work I do is too often confused with the person I am. I am sure I am not the only public figure for whom this occurs but it does repeatedly remind me of the importance of focusing on the issue, not the person is as well as to avoid the temptation to believe everything we hear but judge on what we do know, the facts, not hearsay, rumour or gossip.

More recently first executive members and now delegates and members are facing the media, telling your story and representing yourselves. For many it has required bravery, but the preparedness of RMOs to speak out has I believe been important. Speaking collectively may be the only way we can stand up to bullying, sexual harassment and inappropriate behaviours and within our workplaces to ensure we get the terms and conditions we have fought to achieve.

And our collective strength must be recognised for what it is, and for the weakness it also can pose. The advent of SToNZ has undermined RMOs in New Zealand. Whilst I doubt those that formed SToNZ appreciated the impact they would have outside of simply avoiding schedule 10 at the time they embarked on this journey, they have nonetheless had that effect. That is also something they must now realise. What future engagement between our organisations occurs as it must, will require careful consideration and I suggest a principled approach.

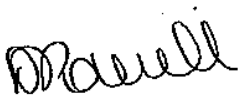
Protecting, enhancing and enforcing terms and conditions of employment remains "core business". In 2019, we will focus on empowering members and delegates to do more of this directly with their own employers. It is also vital that we adapt to the changing environment that is around us and influence change in the right direction. It is after all more your environment, your futures and that of your patients, than that of the managers and in some instances your more senior colleagues. As one example, in 2018 power started to shift away

from the regions and back into the center and who knows what the current review of the sector will suggest: that review is to be released shortly and will no doubt demand some attention.

As I finalise this report just a couple of days after the Christchurch Mosque atrocity, I also wonder at what turn our culture will take. Hopefully one that is overall more tolerant, but maybe also less tolerant of extremism. Culture is inherent to how we live and breathe it is not a cloak we put on when it suits us. We have learnt that trying to change culture within DHBs to simply address bullying and inappropriate behaviour is hard, and whilst there has been change, we have not achieved as much as we would have liked, or expected, I believe in large part due to the lack of cultural change and/or genuine commitment at the top. That may be due to a lack of appreciation of the need to change but the DHBs preparedness to use their power over RMOs to demand greater control over your terms and conditions of employment, is I believe inextricably connected to that culture based in a philosophy of managerial power and control. When judged against the benefits of empowerment, consensus and respect, managerialism in my view, has no place.

We have both cemented and grown our connectedness during 2018 within much of the union movement and with medical organisations. This needs to continue whilst remaining clear on our primary role to represent the best interests of our members. Disagreement and different points of view will occur and will be best managed within a culture of respect and honest dialogue. That eutopia still appears some way off but is nonetheless a goal to aim for.

A huge thanks to the executive and delegates alike for their work in 2018. All have had to step up this year in what has been a frustrating and torrid time. We will get through this and we will continue to deliver to those we represent because we have the collective commitment, energy and wisdom of RMOs in our hearts. We must use our collective for good and protect it or risk those amongst us who are the least able to defend themselves not just from being left behind, but assigned through no fault of their own, to conditions that we banished decades ago.



Dr Deborah Powell
National Secretary