Factsheet #4 – Strike Action and the Union’s Claims

A recent media release from the New Zealand Resident Doctors’ Association (NZRDA) General Secretary, Dr Deborah Powell, announced the Union’s decision to issue notices for a 73-hour strike of DHB-employed RMOs beginning at 7:00am, Tuesday, 17 January.

The strike does not affect Taranaki or West Coast DHBs where there was insufficient support for the action amongst their RMOs.

Strike action by unions led by Dr Powell is hardly unusual: despite representing less than 10% of DHB employees, they used to account for over 95% of strike activity in the DHB sector. It is starting to look like normal service has resumed – do what we want, or face the consequences.

From the media release it is difficult to get a sense of the issues at hand; Dr Powell claims that “negotiations came to a standstill again” – presumably precipitating the Union’s decision to strike – and then that “informal discussions are continuing between the parties”.

The key outstanding issues relate to rostering rules applying to around 140 acute service rosters covering around 1,500 of the 3,700 RMOs employed by DHBs. The 60% of RMOs not directly affected by the roster dispute are employed in Emergency Departments, Intensive Care Units (ICUs) or their equivalents, non-acute services, services that cover after hours through on call, or in a number of cases services where the changes sought by the union have already been introduced.

Moreover, since at least September 2016 the DHBs have agreed to the key elements of the new hours of work limits that the NZRDA have claimed.

RDA describe the outstanding issues as including:

1. **Whether rostered days off will be meaningful and recuperative for resident doctors**
   
The DHBs and the NZRDA have effectively already agreed to RMOs being rostered for no more the 10 consecutive days on duty, and to provide a minimum of 4 days rostered off duty in any fortnight. This arrangement provides ‘meaningful and recuperative’ time for the majority of our clinical workforces.

   What the union is asserting, without any specific evidence, is that in order to be “meaningful and recuperative” rostered days off must be ‘abutting’ a weekend that is itself completely free from rostered duties – i.e. provided as a long weekend. The union effectively thinks that if an RMO was given two extra days off during the week – i.e. a Tuesday and Wednesday – they would not be either recuperative or meaningful (although it would ‘allow’ this in respect of rostered days off after nights).

   The DHBs consider that more flexibility in how the broad limits on workloads might be applied is necessary, and requiring all RMOs to be at work on a Wednesday – as the union’s claim effectively does – ignores the training and service context that is critical to DHBs and, we suspect, RMOs themselves.
2. **How the roster will maintain continuity with teams for patient care and RMO training**

This is an example where the parties agree on the goal, but don’t agree on the mechanism to achieve it.

As above, the NZRDA claim is to lock in through the MECA strict rules that determine what the roster must be for all acute service across the country, irrespective of the nature or size of the service, or the level of the RMOs (Registrar or House Officer) and their training needs.

The DHBs think it’s more complex. We have agreed on the need to address the fatigue issue. We think there needs to be the flexibility for local engagement on how – within the framework that responds to the NZRDA’s fatigue claims – training and patient care issues can be best addressed.

The DHBs don’t think one size will fit all.

3. **Who has the ultimate say on rosters**

The DHBs want to engage with the affected RMOs on how the rostering framework is best implemented in each service, and apply the new hours of work limits giving consideration to RMO training and patient care issues. Reaching a consensus within clinical teams on the appropriate balance of these important elements is the ultimate goal.

In the last settlement the parties agreed to a change process that provided a high-level of engagement and consensus-seeking, and an escalation path that ensures different perspectives and impacts were explicitly considered. Both the DHBs and the NZRDA have agreed this process worked well to promote genuine engagement.

Ideally in the DHBs’ view this process should be retained for addressing the 140 rosters.

In contrast, the RDA want to set absolute rules in place in the MECA and then require agreement by a majority of affected RMOs to implementing these. We are aware that a number of RMOs are expressing concern about the impact of the proposed rules on how they work and train. In a situation where RMOs themselves either disagree with the Union’s industrial claims, or don’t dismiss the potential training and patient care impacts as flippantly as their Union does, the DHBs can’t in good faith agree to the union’s proposal.

4. **Replacing doctors who are getting days off duty as part of the agreement**

While it’s positive to see the union recognises that it’s not just rostered hours that impact on workloads and fatigue, the strangest of the Union’s claims is that, in reducing their hours of work, the DHBs are seeking to increase the workloads of RMOs. This is simply incorrect.

What the DHBs have said is that we don’t think that in introducing the new limits on hours of work, the DHBs should simply default to covering the additional days off individual RMOs receive with leave relievers. The DHBs have said that as part of introducing new rosters, they may want to look at increasing RMO numbers on the core roster in order to ensure a better training experience, rather than just increasing the number of relief runs.